Building Bridges:
Promoting wellbeing for family

PSI WELL

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Program 2016-1-RO01-KA204-024504KA2
Cooperation for Innovation and the Exchange of Good Practices
Strategic Partnerships for adult education Development and Innovation

HANDBOOK
for parents

EDITURA LUMEN
în elita editurilor românești

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BUILDING BRIDGES: PROMOTING WELLBEING FOR FAMILY HANDBOOK FOR PARENTS

Coordinator **Aurora Adina COLOMEISCHI**

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Part I

Promoting resilience and wellbeing within family of disabled children

1. Stress and resilience within family (Romania)

Petruța Rusu
"Stefan cel Mare" University of Suceava

"Ever tried. Ever failed. No matter. Try Again. Fail again. Fail better." (Samuel Beckett)

Abstract

The aim of this book chapter is to provide theoretical and practical information on stress, coping and resilience in families raising children with special needs. The present chapter presents the prevalence of special needs in Europe and reviews studies focused on family stress, chronic sorrow, individual and dyadic coping strategies in family and resilience. Suggestions for stress management are provided to parents; they could find information on special education services and useful online resources in order to cope with stress.

1. Glossary

Stress

- **Family stress –** change, disturbance in the family balance emerging from external factors (e.g. unemployment) or internal issues (e.g. a child disease).
- **Stress spill-over -** intra-individual transmission of stress from one domain (e.g. work) to another domain (e.g. family life).
- **Stress cross-over -** inter-individual transmission of stress from one partner to the other in family relationships

Coping

- **Emotion-focused coping -** managing emotional distress, efforts to deal effectively with emotions in stressful situations
- **Problem-focused coping –** efforts to solve the source of stress
- **Dyadic coping –** stress management process involving both parents, joint coping efforts of the parents, support provided from one parent to the other and cooperative use of common resources in order to cope with stress
- **Religious Coping –** the use of religious behaviours and religious faith in order to find meaning to and cope with the stressful events.

Family Resilience – family competence to adapt, cope with stress and restore the family well-being in adverse situations

2. You are not alone – *Statistics related to children with special needs and their parents*

The diagnosis of special needs (SN; e.g. intellectual disability, autism, Down Syndrome, ADHD, behavioral and emotional disorders, learning disabilities) affects approx. 15 million of families in Europe and 800 million of families worldwide (European Commission, 2012). The prevalence is 1 in 160 children with Autism Spectrum Disorder (WHO, 2017), 1 in 600 – 1000 children with Down Syndrome (European Down Syndrome Association) and 5 in 100 children with ADHD (ADHD Europe), 5 - 12 in 100 with dyslexia (European Dyslexia Association). Over 15% of the word's population live with a specific form of disability (UNICEF, 2013).

Caring for a child with special needs, as a parent, has been found to negatively affect both mental well-being and physical health outcomes. Studies suggest that parents of children with special need report increased levels of stress, depression, anxiety related to the child's future and decreased levels of general well-being (Crnic, Neece, McIntyre, Blacher, & Baker, 2017; McConnell, Savage, & Breitkreuz, 2014; Smith & Grzywacz, 2014). The negative consequences of having a child with special needs on parents' well-being might be explained by their emotional depletion, time demands and financial burden.

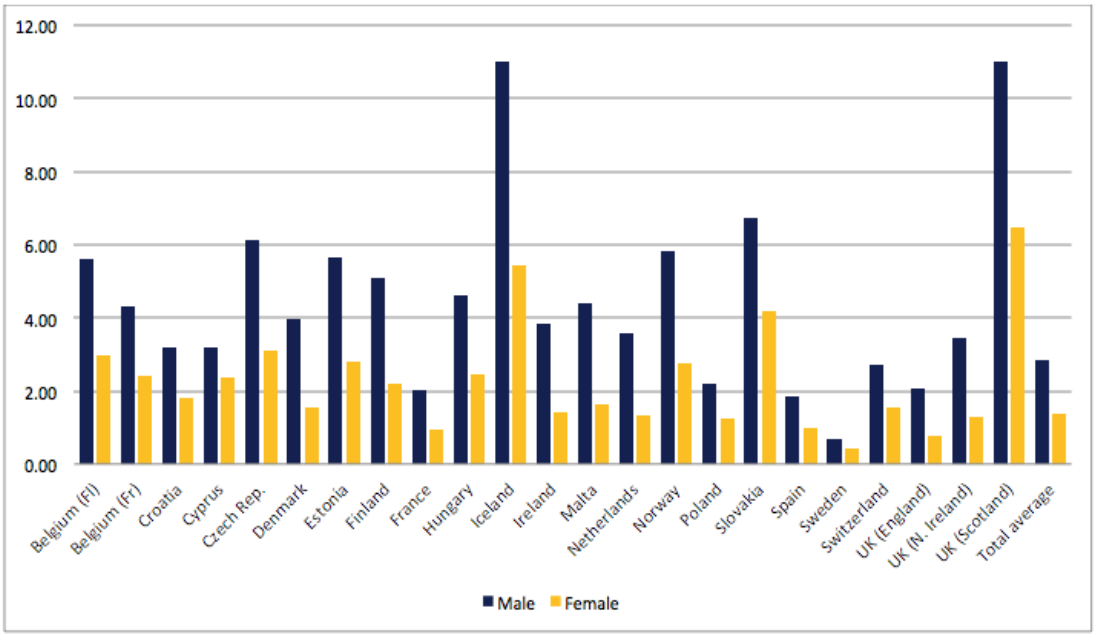

Figure 1. Children with SEN enrolled in schools in Europe

The study conducted in 23 countries identified that there are 1.37% (450,697) girls and 2.86% (942,706) boys that have an official decision of SEN. The ratio for gender distribution is 2:1 (32.35% girls and 67.65% boys).

3. Literature review: Stress in families of children with special needs

Parents learning that their child has special need experience some common reactions, such as denial, anger, fear, guilt, confusion, powerlessness, disappointment and rejection toward the child or towards other family members (McGill Smith, 2003). The Model of Stress in Families of Children with developmental disabilities (Perry, 2004, Figure 2) describes four factors for understanding family stress: Stressors (major and minor stressors related to the child, but also additional life stressors), Resources (individual and family resources for parents), Supports (formal and informal support received by parents) and Outcomes (positive and negative consequences). The ***stressors related to the child*** include his developmental level, cognitive and emotional characteristics. This model disentangle between objective child's characteristics (e.g. IQ) and subjective perception of parents, as sometimes parents of children with mild disabilities may experience considerable higher levels of stress than parents of children with more complex problems. Parents of children with disabilities may experience ***additional stressors***, such as financial stress, work stress or health issues of other family members. These extra- stressors will negatively affect parents' ability to cope with the child disability and parents need support in coping with these stressors as well. ***Individual resources of parents*** refer to personal beliefs, coping strategies, personality characteristics, but also education and employment status of parents. The individual resources of parents play an important role in parents' adaptation to their situation of having a disabled child. For example, an educated, optimistic and religious parent might cope better than a parent with a low level of education, pessimistic and non-religious. ***Family resources*** affecting coping in parents of children with special needs include marital status (single and divorced parents will experience more difficulties than married parents) and the quality of relationship between parents. ***Social support*** refers to informal support (support from extended family, friends and religious community) and formal support (professional support received by parents from educators, counsellors or psychotherapists). Parental outcomes of having a child with special needs refer to both negative effects (such as depression and pessimism), but also positive effects (such as personal growth and resilience). The model of Perry (2004) can help parents to understand different factors contributing to their level of perceived stress. In addition, this model has important implications in counselling families raising children with special needs, emphasizing the protective role of individual, family and social factors.

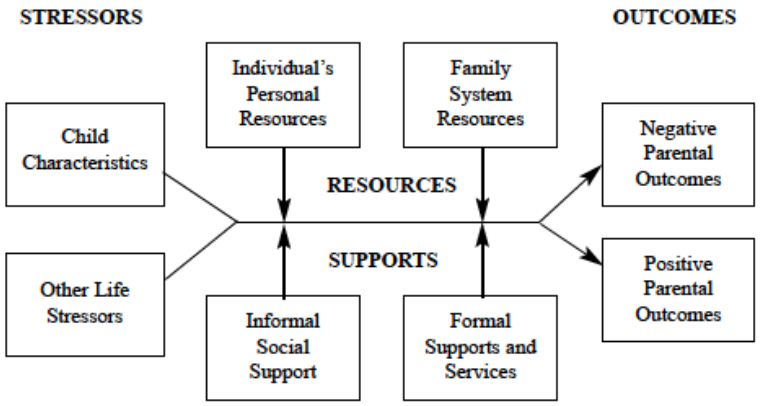

Figure 2. The model of stress in families of children with developmental disabilities (Perry, 2004)

The process of coping with family stress may require different stages. Bodenmann (2005) described the temporal progression of coping in family as the stress-coping cascade (Figure 3). In the case of experiencing a chronic and major stress (such as parenting a child with special needs), we suggest that parents need the entire coping strategies described in the model in order to better adapt to the situation. Therefore, they will use individual coping strategies (such as focusing on finding solutions to the problem, reappraising the situation), but they need support from their partners (dyadic coping) and also social support from extended family and friends and professional help from counsellors and clinicians. Parents may benefit from understanding that they cannot cope with this stress by themselves, they need support from the other parent and they also need to ask for help outside the family. The complexity of stress requires complex coping strategies.

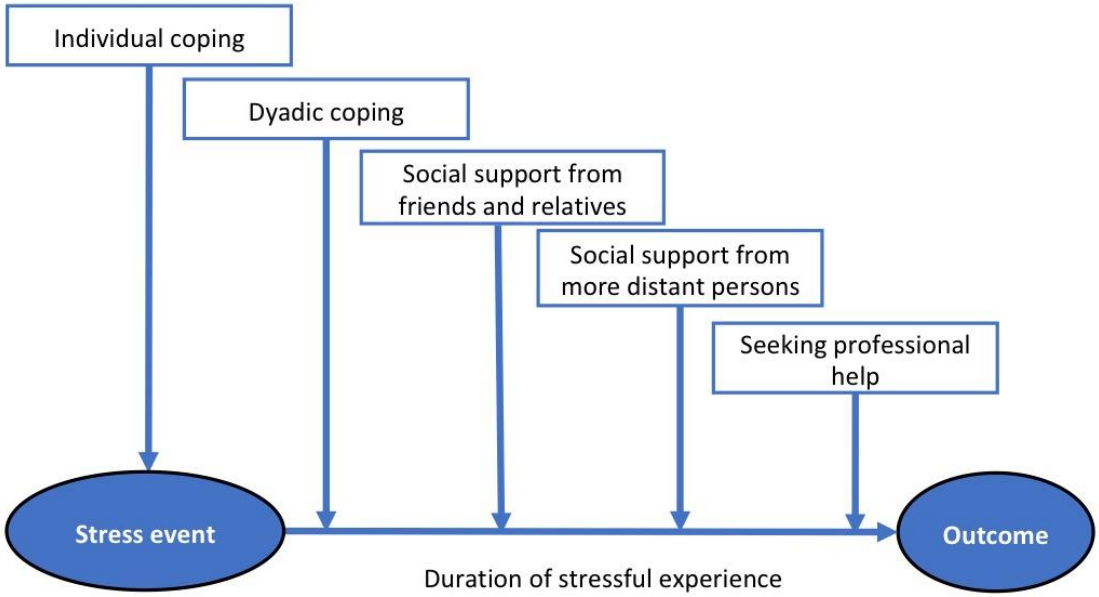

Figure 3. Stress-coping cascade (Bodenmann, 2005)

Chronic stress experienced by parents raising a child with special needs may negatively influence not only the quality of parent-child interaction, but also parent-parent relationship. The Stress-Divorce Model (Bodenmann, 2005) positis that chronic daily stress decreases the quality of marital interactions and may lead to divorce. Parents experiencing chronic daily stress related to their child will spend less time together as a couple and marital communication will be negatively affected. Therefore, it is important for these parents to focus on strengthening their couple communication, to support the other parent in order to cope with stress and to find solutions together for adapt to daily stressors related to the child.

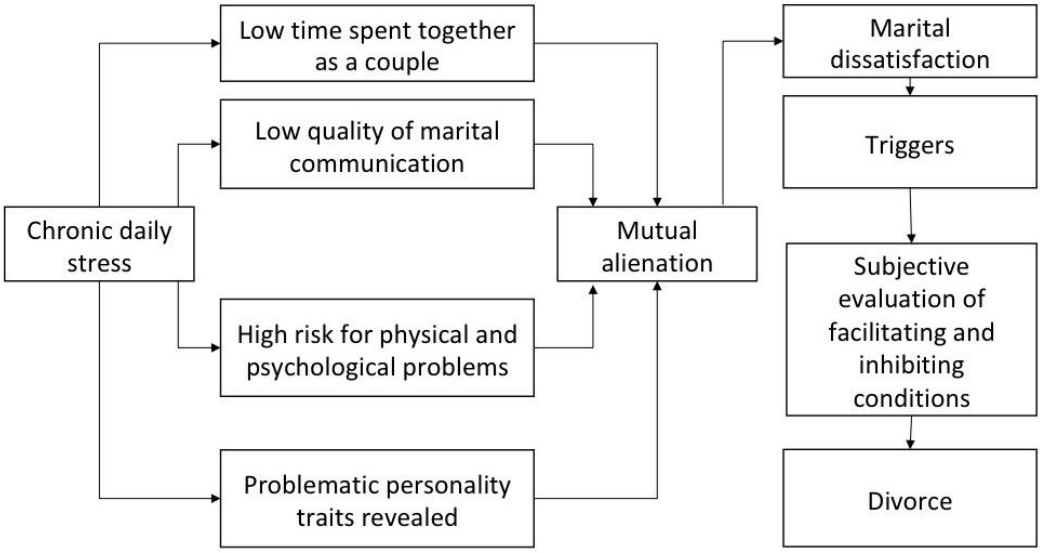

Figure 4. The stress-divorce-model (Bodenmann, 1995, 2000)

According to the Systemic Transactional Model (Bodenmann, 2005), coping is defined as a dyadic concept, involving positive and negative strategies used by both partners to cope with stress together. Positive strategies of dyadic coping include supportive dyadic coping (SDC, one's partner efforts to support the other partner), common dyadic coping (CDC, participation of both partners in the coping process through sharing of feelings, finding solutions to problems or relaxation together) and delegated dyadic coping (DDC, reducing the partner's stress by taking over his/her responsibilities). Both SDC and CDC could be problem-focused (focusing on helping partner to find solutions in the case of SDC or finding solutions together in the case of CDC) or emotion-focused (offering emotional support to the partner, being empathic and understanding in the case of SDC or sharing feelings in the case of CDC). Negative forms of dyadic coping refer to supporting the partner in a negative way, including hostile dyadic coping (disinterest, blaming and minimization of partner's stress), ambivalent dyadic coping (supporting the partner unwillingly) and superficial dyadic coping (supporting the partner without empathy and sincerity).

Empirical evidence suggests that stress is associated with negative relationship outcomes (such as hostile verbal aggression) even for couples with high levels of dyadic coping (Bodenmann, Meuwly, Bradbury, Gmelch, & Ledermann, 2010). Contextual factors, such as stress, may influence dyadic coping resources, as stress negatively affects relationship well-being by 1) creating additional relationship problems (e.g. parents raising a child with special needs may also experience financial strain) and 2) hindering partners energy and resources necessary to cope effectively with stress (parents of children with special needs need more time and energy for child care) (Neff & Karney, 2017). Studies showed that different stressors affect support in couple in different ways. Regarding the explaining mechanisms involved in the negative association between stress and support in couple, previous studies found that stress depletes emotional and self-regulatory resources of partners (McNulty, 2016) and decreases positive emotions of partners (Rusu, Hilpert, Falconier, & Bodenmann, 2017), which in turn affect men and women ability to provide support to their partners. Parenting a child with special needs may affect emotional resources of parents and decrease their positive emotions experienced daily. In consequence, the couple relationship may be negatively

influenced, as these parents do not have resources to support their partners and to focus on positive couple interactions.

Stress of midlife parents raising children with special needs has been associated with long-term negative consequences on parents' health and well-being (Smith & Grzywacz, 2014). Specifically, parents of children with special needs reported more depressive symptoms and more limitations in daily activities compared with parents of children with typical development. However, the study found that these parents become resilient over time, as they develop new competences and attitudes in order to adapt to the child's problems. Therefore, parents of children with special needs need to develop resilience in order to cope with their stress.

a. Chronic sorrow

The concept of chronic sorrow has been first proposed by Olshansky (1962) in order to describe the emotional response of parents having children with intellectual disabilities. In the following years, researchers have started to study this concept in other populations. Chronic sorrow refers to a permanent experience of sadness, loss, guilt and self-blaming, feelings that are recurrent over time (Masterson, 2010). Recent studies revealed that chronic sorrow is related to social isolation and hopelessness for parents of children with special needs. In addition, there are gender differences in chronic sorrow, mothers experiencing more chronic sorrow than fathers (see for review Coughlin & Sethares, 2018). The most important triggers of chronic sorrow are health care crises and developmental milestones (Coughlin & Sethares, 2018).

In previous studies focused on parents' coping with chronic sorrow, different strategies have been identified as being useful. In order to help parents to cope with chronic sorrow it is important to provide them information and resources and to show them compassion. These parents need to receive knowledge, to be supported and encouraged by both health care professionals and by community. Educating people from community to accept, respect and help parents of children with disabilities is an important issue to be addressed. Despite the fact of receiving professional support and participating in specific trainings related to their children' disabilities, these parents need to be socially integrated in the community and not being judged and excluded by parents of children with typical development.

b. Stress management

The most important strategies that parents of children with special needs could use in order to cope with stress (Ambrozich, n.d.; Logsdon, 2018; McGill Smith, 2003) are the following:

- Collect information about the child's special needs and available services in order to help him and learn the terminology about child's disability;
- Read books and blogs written by other parents of children with special needs;
- Join a group of parents experiencing the same problem (online groups are also available for parents of children with different disabilities);
- Rely on other family members or extended network (talk with other parents of children with special needs,
- Expressing emotions and learn how to deal with negative feelings;
- Focus on the present and not worrying about the future;
- Keeping realistic standards and admitting their limits;
- Adopting a healthy life style (exercising, healthy nutrition and healthy sleep);

c. Resilience

Bodenmann (2016) classified the factors infleuncing resilience in family in the following categories: individual factors, family factors, social factors and ecological factors of resilience. We are going to explain these factors in the following section.

Individual factors:

• *favorable personality traits* (friendly character, amiability, independence, psychological stability and well-adjusted temperament, positive self-esteem, intelligence, extraversion, tolerance, openness to novelty);

• *elevated competences* (problem-solving skills, social competences, emotion regulation competences, coping with stress, relationship skills).

Family factors influencing resilience:

• *family cohesion*

• *family adaptability*

• for the resilience of children: a) *emotional stability of parents*, constant and strong bonds between parents and children and b) *sensitivity and trustworthiness of parents* for the education of secure bonds, internal locus of control and a positive self-esteem;

• *authoritative-constructive education*, characterized by emotional warmth, love, acceptance, appreciation, support, clear structure with rules and borders, consistence within person and between parents in the child education;

• *family rituals* (having the meals together, celebrations of birthdays and other festivities and traditions);

• *time for children,* not only the quantity of time, but the quality of time spent together is important. Parents should show their children full attention, interest and care;

• *few destructive conflicts between parents and the absence of divorce;*

• *mothers having a job* is an important factor of resilience, as working mothers have a greater level of well-being due to the social integration, personal balance, independence for the partner and professional fulfillment.

• *religiosity;*

• *number of children in the family.* An important resilience factor is having less that 4 children, separated by at least 2 years, so that parents can give each child the attention and importance he or she deserves. In general families with more than four children experience higher levels of stress;

• *the timely use of support* services by parents experiencing psychological issues, couple and family problems. Asking for help in time of need (e.g. participation in courses, counseling, specialized therapy) is an important factor of family resilience.

Social factors of resilience include support form colleagues, neighbors, members of extended family and teachers, being part of social groups, but also leisure activities and hobbies of family members.

Ecological factors of resilience are related to the living conditions (quality of housing and living environment, security) and opportunities in the neighborhood for families (e.g. playgrounds).

Peer & Hillman (2014) conducted a systematic literature review on parents of children with intellectual and developmental disabilities and identified three resilience factors for these parents: ***coping style, optimism and social support***. Specifically, the authors suggested that problem-focused coping (focusing on finding solutions to the specific demands that parents experience) is a

protective factor for parents' stress and it is more related to parents' well-being than emotion-focused coping (focusing on regulating the emotions determined by the specific situation). Moreover, dispositional optimism (having a positive view of the situation and positive expectations for the future) has been found to have positive consequences on parents' well being. Finally, the availability of social support from extended family, friends and community, but also professional help (being part of support group, receiving psychological counseling) are important factors of well-being for parents of children with disabilities.

A study investigating resilience of parents raising children with disabilities and behavior problems suggested that ***financial situation and social support*** are the most important factors for a good family functioning and family resilience (McConnell et al., 2014). The study found that parents of children with disabilities are better adapted and have a better family functioning when their financial strain is low and their social support is high. Therefore, the contextual factors are very important for the well-being of families raising children with special needs and not only the individual factors (e.g., coping, optimism, social and emotional competences) and family factors (e.g., family adaptability and cohesion, the quality of family interactions). Previous research studies revealed that economic stress has a negative influence on family life, affecting the quality of interactions between spouses. Economic strain was linked to declines in supportive dyadic coping for both males and females (Johnson, Horne, & Galovan, 2016; Rusu et al., 2017).

4. Quizz (e.g. What is your stress level?)

Quizz 1: Parental Stress Scale (Berry & Jones, 1995)

The following statements describe feelings and perceptions about the experience of being a parent. Think of each of the items in terms of how your relationship with your child or children typically is. Please indicate the degree to which you agree or disagree with the following items by placing the appropriate number in the space provided.

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1	I am happy in my role as a parent	1	2	3	4	5
2	There is little or nothing I wouldn't do for my child(ren) if it was necessary.	1	2	3	4	5
3	Caring for my child(ren) sometimes takes more time and energy than I have to give.	1	2	3	4	5
4	I sometimes worry whether I am doing enough for my child(ren).	1	2	3	4	5
5	I feel close to my child(ren).	1	2	3	4	5
6	I enjoy spending time with my child(ren).	1	2	3	4	5
7	My child(ren) is an important source of affection for me.	1	2	3	4	5
8	Having child(ren) gives me a more certain and optimistic view for the future.	1	2	3	4	5
9	The major source of stress in my life is my child(ren).	1	2	3	4	5
10	Having child(ren) leaves little time	1	2	3	4	5

	and flexibility in my life.					
11	Having child(ren) has been a financial burden.	1	2	3	4	5
12	It is difficult to balance different responsibilities because of my child(ren).	1	2	3	4	5
13	The behaviour of my child(ren) is often embarrassing or stressful to me.	1	2	3	4	5
14	If I had it to do over again, I might decide not to have child(ren).	1	2	3	4	5
15	I feel overwhelmed by the responsibility of being a parent.	1	2	3	4	5
16	Having child(ren) has meant having too few choices and too little control over my life.	1	2	3	4	5
17	I am satisfied as a parent.	1	2	3	4	5
18	I find my child(ren) enjoyable.	1	2	3	4	5

Scoring instructions: In order to calculate your stress score for the perceived Stress Scale, firstly reverse your answers to the following items: 1, 2, 5, 6, 7, 8, 17 and 18 (1 to 5, 2 to 4, 3 remains 3, 4 to 2 and 5 to 1). For example if your answer is 2 for the first question, you have to transform it into 4. Secondly, sum up your answers to all the 18 items (both the reversed ones and the non-reversed ones). A total score higher than 54 indicates a medium to high level of stress. Discuss this result in the PsiWell training program for parents of children with special needs related to the current project.

Quizz 2: *Reflect on the level of stress you have experienced in last week and then in the last 12 months related to your job, social relationships, free time, family of origin, living situation, finances and daily hassles. These factors may negatively influence your ability to cope with the stress related to your child's special needs. In order to be a better resource for your child and to reduce your general level of stress, try to cope effectively with additional stressors in your life.*

Multidimensional Stress Questionnaire for Couples (MSF-P, Bodenmann, Schär, & Gmelch, 2008)

	How stressful/straining are the following situations <u>outside</u> of your relationship? This concerns stress which isn't connected to your partner.	Burden/stress during the past							
		7 days (acute)				**12 months (chronic)**			
		not at all	slightly	average	strong	not at all	slightly	average	strong
MSFP 15	**Job/education** (commotion, deadline pressure, high demands, being unchallenged, lacking acknowledgement, career opportunities, etc.)	①	②	③	④	①	②	③	④
16	**Social contacts** (conflicts with neighbors, colleagues, acquaintances, social commitments, gossip, etc.)	①	②	③	④	①	②	③	④

17	**Free time** (deadline pressure, too many activities, unsatisfactory recreational activities, too little time for yourself, pressure to perform, etc.)	①	②	③	④	①	②	③	④
18	**Children** (child care, upbringing, interactions, dependence, restrictions, worries about the children, etc.)	①	②	③	④	①	②	③	④
19	**Family of origin** (separation and dependence, conflicts, maintenance, etc.)	①	②	③	④	①	②	③	④
20	**Living situation** (apartment size, noise, site, etc.)	①	②	③	④	①	②	③	④
21	**Finances** (debts, lack of money, no raise in salary, etc.)	①	②	③	④	①	②	③	④
22	**Daily hassles** (losing or misplacing things, frequent disturbances, waiting lines, traffic jams, delays, etc.)	①	②	③	④	①	②	③	④

5. Where can you find assistance and ask for special help? Special Education Services

- School based support services (school counsellors, educators, school psychologists);
- Local organizations focused on children with different special needs (e.g. autism);
- Trainings and projects for parents of children with special needs developed by Universities;
- Support groups for families of children with special needs (local groups and online groups).

6. Resources for stress management in parents of children with special needs

Helpful Websites

• Center for Parent Information and Resources
http://www.parentcenterhub.org/steps/
• Support for parents of kids with special needs
https://kidshealth.org/en/parents/parents-support.html

Videos

• Managing stress as the parent of a child with special needs
https://www.youtube.com/watch?v=NCwy5ZtmXKM
• Mastering daily life
https://www.youtube.com/watch?v=fh8dHWHDz6M

• Coping with stress for families of children with autism https://www.youtube.com/watch?v=hZxvdbgJ88c

Associations and Societies

• Autism Society
http://www.autism-society.org/
• Association of parents with children in special education
http://www.napcse.org/

Blogs

• Day by day with developmental delay
http://developmentaldelays.blogspot.com/
• Hopeful parents
http://www.hopefulparents.org/

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2. Family resources

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The family is probably the oldest and most resilient institution of society. The family is appreciated and celebrated throughout the world. Since the beginning of life on Earth people have been grouped into families to find emotional, physical and collective support. Although in recent years several voices predict failure for both family and marriage, they continue to survive, change, and evolve.

Most family studies, historically speaking, focused primarily on issues or weaknesses. However, in the last three decades, researchers have studied families in a perspective that highlights the strengths and family resources. Throughout the world, researchers have found that families are amazingly similar. The similarities indicate a set of qualities that describe the characteristics of powerful families. These qualities show appreciation and affection, commitment, positive communication, pleasant time spent together, spiritual well-being and the ability to effectively manage stress and crises (DeFrain & Asay, 2007).

Family resources - conceptualization models

The issue of family resources is frequently studied by researchers in the context of family stress and the difficulties that may arise as a result of large-scale traumatic events or ordinary life situations but which require a certain capacity to cope with the problem.

An operational definition of family resources is set forth by Panganiban-Corales and Medina Jr. (2011). Researchers present family resources as family-friendly means to deal with difficult situations, and these family resources consist of:

- social resources (social support network represented by husband, wife, children, parents, brothers, neighbors, colleagues, etc.);
- cultural resources (cultural values that can influence the individual's or family's ability to cope with stress, for example, optimistic vision, family approach vs. avoidance approach);
- religious resources (spiritual beliefs, spiritual support services, religious practices);
- economic resources (family income);
- educational resources (the level of formal education attained by a person that allows him to understand the condition, the need or condition of the suffering person, thus managing to provide the necessary care);
- medical resources (accessibility to health facilities and appropriateness of health service providers) (Panganiban-Corale & Medina Jr, 2011).

Another resource approach, both at the individual level and at the family level, is represented by the Conservation of Resources Theory (Hobfoll, 1989). This theory is an integrated model that incorporates several approaches to stress. In line with the resource conservation model, people tend to accumulate and maintain resources, including objects (eg clothing, food), personal characteristics (for example, self-esteem), living conditions (for example, being married or living with someone

gives social support, increased financial security) and energy (eg time, money, knowledge). Stress occurs when there is a loss of resources or the threat of a loss. Resource conservation theory considers resource transformations to be central to understanding stress and the coping process. This is critical because the availability of resources largely determines the efficiency with which people, families and communities can adapt to trauma.

Hobfoll (1989) defines resources as those things that people value them, with emphasis on objects, states, conditions, etc. An evaluation of literature in the last two decades by Halbesleben, Neveu, Pautian-Underdahl and Westman (2014) highlights the analysis of resources such as:

- job security;
- rewards;
- autonomy, authority of decision, control participation in decision-making;
- opportunities for professional development;
- social support from family, boss, colleagues, partners;
- time spent away from work to recover energy;
- self-esteem, self-efficacy, locus of control;
- conscientiousness, emotional stability (Halbesleben, Neveu, Paustian-Underdahl, & Westman, 2014)

Thus, the Conservation of Resources Theory (Hobfoll, 1989, 1998) provides a means of understanding the impact of stress and trauma on the family and on the individual level, as well as a way to deal with this impact by preventing the loss of existing resources and obtaining other resources needed for coping.

Interpersonal resources, such as social support, allow the provision and exchange of resources outside the individual. Although interpersonal resources can help families to cope with trauma, social networks can also have a negative impact, acting as a channel through which the effects of stress are spread throughout the family, thus contributing to the spiral loss of other resources. In other words, the Conservation of Resources Theory argues that interpersonal traumas from families (eg conjugal abuse) can cause spiraling loss of interpersonal resources, such as re-victimization of the victim, which keeps the continuing loss of resources.

Another theoretical model of adapting families to traumatic situations and the way they manage to activate their resources to cope and adapt to stress is the ABC-X double model developed by McCubbin and Patterson (1983) (fig. 1). This model was analyzed especially in the context of situations where a child suffers from a chronic condition such as autism or other disabilities (M. M. Bristol, 1987).

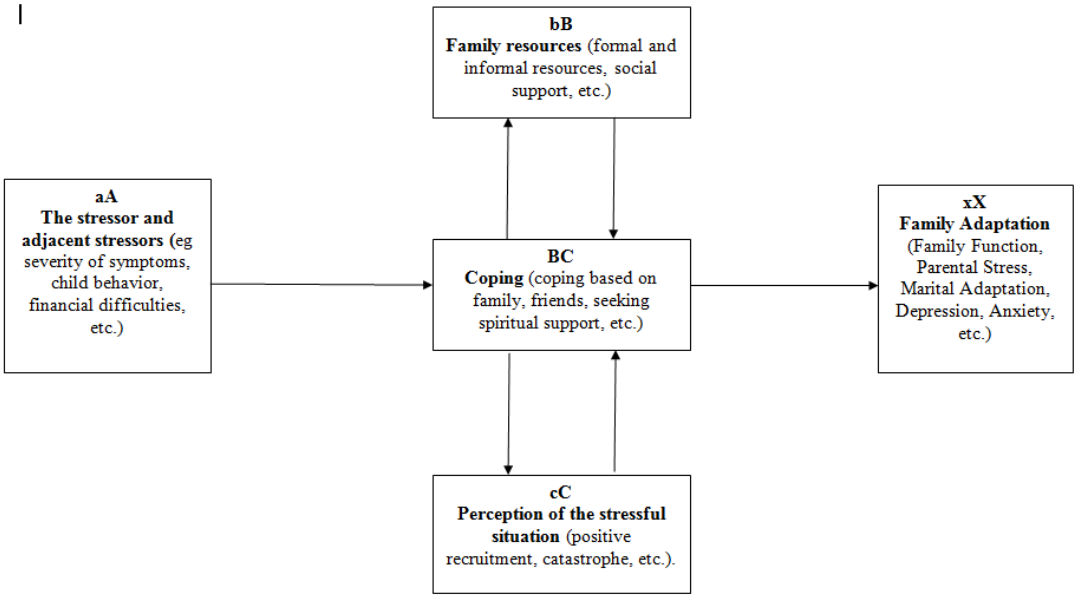

Figure 1. The Double ABCX Model of family adaptation (Maccubbin & Patterson, 1983)

The Double ABCX Model (figure 1) starts with the stressor element (aA) plus other adjacent stressors. The initial stressor is defined as a life event or a transition event that affects family unity and has the potential to produce changes in the family's social system. For example, many studies have shown that in the situations of families with autistic children, the symptoms of children (especially difficulties in social skills) are predictors of parents' stress and depression (Abbeduto et al., 2004; Dumas, Wolf, Fisman, & Culligan, 1991; Lecavalier, Leone, & Wiltz, 2006). Moreover, in addition to major stress, the loggency studies in these families suggest the influence of other stressors connected with major stress: divorce, financial difficulties, job loss, etc (Manning, Wainwright, & Bennett, 2011).

In addition to the main predictor (stress factor), the model contains two moderating variables: family resources useful to meet the needs (bB) and the sense that the family attributes to the situation they are experiencing (cC). By analyzing family resources, they are both social and psychological in nature and allow for adaptation to the demands of the stressful situation by satisfying the additional requirements that arise. Social support is one of the most important resources the family can access and consists of formal and informal social support. This resource has proven to be the most powerful factor associated with success in child care, as well as reducing emotional problems, depressive symptoms, increasing marital satisfaction and diminishing social isolation (Marie M Bristol, 1984; Dunn, Burbine, Bowers, & Tantleff-Dunn, 2001).

A study based on data from interviewing mothers with disabled children, showed that mothers taking part in group discussions involving other people with similar experiences had a much better evolution in their adaptation process (Skinner, Bailey Jr, Correa, & Rodriguez, 1999). Also, Rodrigue and his collaborators (1990) have shown that participation in small but well organized support networks is associated with an effective adaptation of autistic families (Rodrigue, Morgan, & Geffken, 1990). The significance that a family gives to the circumstances they are experiencing is the second moderating component of the model (cC). This variable refers to the perceptions of the family or the meaning it gives to the crisis situation. For example, relapse is a cognitive evaluation strategy that can have positive effects, allowing the situation to be assessed in a positive light

(Folkman & Moskowitz, 2000), especially in extreme conditions where it is very difficult to act directly to reduce the impact of the stressor (Hastings, Kovshoff, Ward, et al., 2005). Recruitment was associated with low depression levels for both mothers and fathers of children with school-age and pre-school age autism (Hastings, Kovshoff, Brown, et al., 2005). Research has also suggested that positive perceptions are a resource factor that improves the impact of child disability on family members (Hastings & Taunt, 2002).

The ABCX model links the two moderate variables presented above: [Resources (bB) and Perception (cC)] with a mediator concept, namely, coping strategies (BC). Coping is understood as a mechanism that helps restore balance in family functioning. McCubbin and Patterson (1983) suggested that understanding how family adaptation to the crisis situation can be achieved by simultaneously examining family resources, perceptions, and how the family cope with the stressful situation. Therefore, family coping is a link concept that has cognitive and behavioral components and interacts with family perception and resources, and the result is balanced family functioning (Maccubbin & Patterson, 1983).

The result of the model is family adaptation (xX). This occurs on a continuum and ranges from a positive adaptation to a negative adaptation or poor adaptation (Maccubbin & Patterson, 1983). Family Adaptation is the main concept of the ABCX model and is used to describe the outcome of family efforts to achieve a new level of balance and functionalty (Keller & Honig, 2004), symptoms of psychiatric disorders (M. M. Bristol, 1987; Carnes & Quinn, 2005; Pakenham, Samios, & Sofronoff, 2005), marital adjustment (M. M. Bristol, 1987), parenting quality (M. M. Bristol, 1987), subjective health status (Pakenham et al., 2005), parental stress, family functioning (Manning et al., 2011).

In conclusion, ABCX authors argue that a parent's ability to cope with a traumatic situation is determined by the interaction between the stressful and other adjacent stressors (aA), family resources, parents' perceptions about the problematic situation, and coping strategies. The result of this interaction is the level of family adaptation, ranging from a severe stress crisis to a successful adaptation (Maccubbin & Patterson, 1983).

In the following we will analyze the informal family resources such as: family communication, family time, family strengths, healthy relationships, and self-esteem and others.

a. Family communication

Communication is the nucleus of processes that take place at family level. Family processes are strategies on which the family is working to achieve objectives, to cope with changes to overcome certain obstacles. While some strategies are less obvious, others are more expressive, more visible and rely on a particular style of communication. The way family members communicate, the issues they communicate, and how they solve problems are examples of expressive family processes (Day, 2002).

Researchers in the field of family communication supports the idea that studying this process is like looking at a ray of light through a prism that projects the colors of a rainbow on the wall. Rainbow colors are the information we see and that tells us about hidden goals, deep convictions, expectations of everyday life, and interaction at the level of relationships. Communication is the process that makes sense and expounds outward feelings, dreams, desires, etc. Also, most researchers in the field of family relationships consider effective communication to be the focus of strong

families. Instead, when couples face difficulties in the relationship, the style, content and intent of communication lead to the identification of the problem that at first glance seems insensible (Day, 2002). In this regard, Virginia Satir, family therapist and author of several volumes and articles on family communication, emphasizes the importance of analyzing this aspect for understanding family life "once the human being was born, communication is the only factor determining the type of relationship which he/she binds with others and what happens to him/her in the world " (Satir, 1972, p.30). So, as mentioned above, when we enter into new relationships, a first task is to develop an individualized message system.

Family communication is the mechanism that causes the most early socialization experiences. By observing and interacting with family members, most people learn to communicate and, perhaps more importantly, learn to think about communication (Bruner, 1990). From a very early age - some even before birth - children engage in social interactions with their primary carers, in most cases parents (Barratt, 1995). These early interactions are the basis for what later become automated communication behaviors (Cappella, 1991). They also serve as a model for future interactions (Bowlby, 1973). By communicating with close family members, infants and children learn quickly how relationships works and how they should regulate their own communication behavior in interactions with others. Communication is therefore the means by which the rules are established on interaction and social relations (Shimanoff, 1980). Parents use communication to teach children when they should talk, who they should and what they should say. These rules build how children, and later adults, coordinate meaning with others (Pearce, 1976).

On the other hand, communication is the mechanism by which family members establish and dissolve their intimate relationships. People form their families through social interactions. Through pairing communication, they are able to evaluate how interaction goes, the relationship status, the compatibility level (Berger, Gardner, Clatterbuck, & Schulman, 1976; Surra, Arizzi, & Asmussen, 1988). After the formation of the family, the members continue to relate each other through co-ordination. Spouses use communication strategies to maintain their marriage (Canary & Stafford, 1992). Child and adolescent relationships with parents are influenced by both: the amount and the type of interaction at the level of these relationships (Stafford & Bayer, 1993). At the same time, the conclusion of some relationships is also mediated by the communication process. For example, divorce is associated with a certain type of communication (Gottman, 2014). Another argument that explains researchers' interest in family communication is that it provides a way to predict the quality and timing of family relationships. For example, they argue that for a long time this communication process is an indicator of the quality of marital relationships. Thus, couples experiencing high levels of stress generally express more negative affects, but fewer positive emotions than those who are less stressed, and these expressions of affections manifest themselves bidirectionally in the marital relationship (Margolin & Wampold, 1981; Notarius & Johnson, 1982). Moreover, when initial levels of satisfaction are controlled, the expression of negative affects in marriage predicts diminishing satisfaction over time (John M Gottman & Krokoff, 1989; Huston & Vangelisti, 1991; Levenson & Gottman, 1985). In addition to reflecting the quality of family relationships, communication that links to family members (eg, marital couple) can influence the communication of members of another subsystem (eg parents) or may influence other family members (eg children). Studies have shown that the quality of parental communication can affect children's problem-solving abilities (Goodman, Barfoot, Frye, & Belli, 1999) and friendship skills (Burleson, Delia, & Applegate, 1995). Also, parents' tendency to engage in certain conflicts is associated with children's distress (Grych &

Fincham, 1990). At the same time, family communication predicts patterns in the quality of family relationships, and these patterns also provide an indication of how the family faces structural changes such as the birth of a child (MacDermid, Huston, & McHale, 1990) or remarriage (Coleman, Fine, Ganong, Downs, & Pauk, 2001).

The communication process varies by generation, gender, and experience levels. When families try to better understand different styles of communication, they manage to reduce criticism. Many communication problems are caused by differences in perception or the way they interpret the same information. These differences can be reduced if one is willing to enter the inner world of another person. Covey (1989) says that when family members shout, the message usually means "understand me", "listen to me", "obey me." Thus, it is recommended that each member of the family learns to be patient and to control himself - to listen first and to speak later. By expressing his anger in excess, it leads to guilt and shame in family interactions and makes relations cool. The general goal sought in family interactions is to create a state of trust for expression where everyone can win. Creating such a state is mediated by the frequent use of proactive language, for example, "Consider options available to us", "I prefer another approach, is that possible?" or "I understand your point of view." Thus, to improve communication within the family, the following suggestions may be considered (Covey, 1989):

- giving real time every day to communicate with family members;
- initiating sentences with "I" instead of "you";
- expressing only what we feel, believe, want or need, etc. and not what another person feels, thinks, wants or needs, etc .;
- it is important to ask for feedback whenever possible
- instead of automatically rejecting or disagreeing with someone's opinion or question, their own words can be said about what has been said;

when someone speaks, listen to it carefully;

- leave everything to one side and look at your interlocutor in the eye, give it all your attention;
- pay attention to nonverbal messages as well as verbal messages.

b. Family time

According to a survey by Nielsen, parents spend about 39 minutes a week in conversation with their own children. Time spent with children has effects on their well-being, correlates negatively with substance use and positive with improving mental health and social competence (A. Bowen, 2013).

Adolescents report fewer stress symptoms, a higher level of happiness when they eat with both parents (Offer, 2013). In addition, those who perform leisure activities with their parents are less stressed, and the parent-child relationship is much stronger (Crouter, Head, McHale, & Tucker, 2004). These data highlight the importance of the role of both parents as an impact factor for the well-being of the child.

Family time is also a subject addressed by Daly (1996). It suggests that there is often an imbalance or a lack of connection between what families consider important (their ideology) or what they want and what they actually do in terms of time spent together. Daly states that time spent with the family does not have the same meaning for all families. For example, ideas promoted in Western culture on this subject tend to focus on the importance of spending time together with children and

communicating more effectively. This type of theory also supports the idea that families who spend more time together are stronger and can achieve their goals (Daly, 1996).

However, the time spent with the family has been greatly reduced or becoming more and more difficult to achieve due to the very busy work schedule that family members have, but also because of the daily everyday rhythm. Under these circumstances, Daly suggests that some people have two families, one in which they live and one they live with, and often the two do not actually meet. In addition to these issues, he points out that families are heavily constrained and the amount of time they use to solve certain problems. In addition, there are differences between what children want, what they want in terms of time spent together. Parents usually report the desire to spend more time with their family to do activities. Children simply want to spend more time with their parents (Daly, 1996). Other studies on children's opinion about time spent with family (Christensen, 2002; Daly, 2002) highlight the importance that children provide for simple, routine activities such as day-to-day conversations with parents. Turning off your TV, mobile phone, computer while on the table, when cleaning the house or any other simple activity together adds to the quality of your family time. Playing moments are other examples that can improve the quality of family time and therefore the feeling of satisfaction and well-being is amplified (A. Bowen, 2013).

As Daly (1996) pointed out, the time spent with the family is getting smaller in recent years (Daly, 1996). However, in such conditions, the quality of time and activities becomes more important. Quality time is a time dedicated to the whole family where activities are performed to everyone's liking, especially children. Unfortunately, this time is often sacrificed because of the pressure and demands of parents at work, causing feelings of stress, guilt and frustration (A. Bowen, 2013). Also in this direction, Daly's research has shown that most of the families he has studied are quite stressed over time spent together. For example, parents report higher levels of guilt about the inability to spend time with family members. It also finds that the main strategy to deal with guilt is to offer other benefits to family members (for example, gifts) rather than changing the program change to have more time available (Daly, 1996).

A report by the Disability Institute at Wyoming University (A. Bowen, 2013) presents various suggestions to improve the quality of time spent together, such as:

- everyday moments can be more enjoyable if the focus is on conversation:
  - parents can expect their children from school and can spend time (without being interrupted by phone) to discuss with them;
  - the meal can be prepared together;
  - the meal should be taken together at least once a day;
  - avoiding contradictory discussions at the table;
  - addressing specific questions about daily activities;
  - initiating talk about the best / worst part of the day so everyone can have an opportunity to express themselves;
  - developing the work / themes together and providing answers if questions arise from children;
- for special moments:
  - distractions (TV, telephone, etc.) should not be allowed;
  - the child should be able to choose the activity;
- strategies to spend pleasant time with family could be:
  - practicing / watching outdoor sports;

- watching movies together;
- card, soccer, puzzle games;
- reading books out loud;
- identifying and practicing common hobbies (fishing, camping, building together, working on a joint project, etc.).

c. Family strengths

Sharpening the strengths of the family brings a more reasonable balance to understanding how families manage to overcome the difficulties of life. By concentrating our attention only on the family's problems and failures, worth noting, thus a positive outlook is needed to succeed. The outlook of family strengths is a positive, optimistic, life-oriented orientation and reliance on research throughout the world. Family issues are not ignored, but they are restructured and rebalanced.

In the past three decades, researchers at the University of Nebraska-Lincoln led by John DeFrain, of the University of Alabama-Tuscaloosa led by Nick Stinnett of the University of Minnesota-St. Paul led by David H. Olson, plus other affiliated institutions in the United States and across the world have studied families from a prospect-based perspective. The results highlight a set of similar features that describe the characteristics of powerful families. Thus, people in different cultures identify common features for a strong family, and these characteristics are (DeFrain & Asay, 2007):

- appreciation and affection:
  - care of one another;
  - friendship;
  - respect for individuality;
  - humor;
  - playful character;
- commitment:
  - confidence;
  - honesty;
  - reliability;
  - fidelity;
  - sharing;
- positive communication:
  - offering compliments;
  - sharing feelings;
  - avoiding blame;
  - have the ability to compromise;
  - acceptance of disagreement and differences of opinion;
- time spent together:
  - the quality of the time in a sufficient quantity;
  - the joy of being in the company of others;
  - simplicity;
  - sharing pleasant moments;
- well-being
  - hope;

- faith;
- compassion;
- sharing ethical values;

• the ability to cope with crisis situations:

- adaptability;
- interpreting crises and challenges as opportunities;
- growing together through crisis;
- opening up to change;
- resilience.

Research on strong families has led not only to models for a better understanding of the qualities of powerful families. He also suggested a number of phrases that are relevant to how we look at families in general and how we can live successfully in our own families (DeFrain & Asay, 2007):

• *Families, in all their remarkable diversity, are the fundamental foundation of human cultures.* Strong families are essential for the development of powerful communities, and powerful communities promote and build strong families;

• *All families have strong points.* All families have challenges and areas of potential growth. If someone only looks for problems in a family, they will only see problems. If someone searches for strengths, it will find strengths;

• *It is not about structure but about operation.* When talking about families, we usually make the mistake of focusing on the family's external structure or family type, rather than on the internal functioning of the family. In fact, there are powerful monoparental families, large, nuclear, extended, with homosexual or lesbian members, etc;

• *Strong marriages are the center of many powerful families.* The relationship of couple is an important source of power in many families with children. Parents must find ways to develop a positive couple relationship for the good of all family members;

• *Strong families tend to have wonderful children;*

• *If a person has grown up in a strong family, it will probably be easier to build a strong adult family.* But it is also quite possible to succeed even if he had not been lucky and grew up in a family with serious problems;

• *The relationship between money and family is insufficient.* Once a family has adequate financial resources, uninterrupted search for more revenue is not likely to increase the quality of family life, happiness or the power of relationships;

• *Strengths develop over time.* When couples decide to live together, they sometimes have difficulty adapting to each other, and these difficulties are quite predictable. Adjusting to each other is not an easy task. Many couples are unstable before they come to create a healthy, happy family;

• *Strengths are often developed in response to challenges.* The couple and the strengths of the family are tested by daily stressors and significant crises they face;

• *Members of strong families tend not to think too much about their strengths, just to live them.* However, it is useful to look at the strengths carefully and discuss precisely how family members use them as an advantage;

• *Strong families as well as humans, are not perfect.* Even in the most powerful families, sometimes problems may arise. But there is also a considerable need for reconciliation with each other, the

search for understanding and support. A strong family is a work of art in constant progress, always under development and change;

• *When you seek to unite groups of people, communities and even nations, a strong strategy would be to unite them around the cause of the strengthening of the family;*

• *Human beings have the right and responsibility to feel safe, comfortable, happy and loved.*

d. Healthy relationships

The family is studied by researchers, both inside and outside of the family unit, from a family-based perspective. From this perspective, the family is considered a complex set of combined actions, all of which are influenced by more general social and cultural factors, as well as the individual characteristics and behaviors of each family member.

During the 1960s, family-specific communication therapists such as Bateson, Jackson, and Haley formulated a theory about healthy family functioning (eg Jackson, 1965) based on ideas proposed by General Theory of the Systems proposed by Von Bertalanffy (1950). These ideas convey that families based on healthy relationships are described as functional systems that, like any kind of living systems, depend on two important processes (Maruyama, 1963). First it must maintain integrity in the face of environmental disturbances. This is done by negative feedback, often illustrated by the example of a thermostat in the house heating system. When the heat drops below a set point, the thermostat activates the heater until the air in the room returns to the desired temperature.

No living system can survive without a regulation structure, but a rigid structure can balance it inefficiently, so adapting to the circumstances of change would become too difficult or even impossible. This is why normal families with structured healthy relationships have positive feedback. Negative feedback has the role of reducing the impact of change to maintain a steady state; Positive feedback alternates the system to accommodate new entries. For example, as children grow older, their reporting to the family system changes. The most obvious example is adolescence when children require more independence. A family system limited to negative feedback produces resistance to such changes. Families with healthy relationships, on the other hand, have positive feedback mechanisms and can respond to new information by changing relationships structures and interactions (Nichols & Schwartz, 2005).

Families with healthy relationships become periodically unstable (Hoffman, 1971) during transition periods in the family life cycle. No family goes unperturbed over these periods. Everyone experiences stress, resists change, and develops vicious cycles. But flexible families are not caught in these cycles but are capable of engaging in positive feedback to change. Symptomatic families, with problematic relationships, remain stuck and resist in an unhealthy manner of change. Healthy families are able to change because they communicate clearly and flexibly. For example, when their children say they want to grow up, parents are listening and making changes in attitude, behavior (Nichols & Schwartz, 2005).

Another important feature of family therapy, whose principles of analysis and intervention techniques and strategies are popular today, is Virginia Satir. It describes relationships in healthy families as based on direct and honest communication, where differences are confronted, and emotions are expressed openly. Under these circumstances, Satir says that people develop a healthy self-esteem that allows them to assume the necessary risks for authentic relationships (Satir, 2010).

In the 1970s, Murray Bowen, a psychiatrist and systemic family therapist, laid the foundation for a theory that focuses on the impact of the family's origin on subsequent relationships in the life of every individual (M. Bowen, 1976). Based on Bowen's ideas, Cater and McGoldrick (1999) described the family life cycle as a process of expanding, shrinking, and realigning the relationship system to support the entry, exit, and development of family members (McGoldrick & Carter, 1999). Thus, at the stage of leaving the home, the primary task for young adults is to separate themselves from their families without fleeing to an emotional substitute. It is time to develop an autonomous way of being, before forming a couple with another person and creating a new family. In the family marriage union, the primary task is to make a new couple. This is not just a simple union of two individuals, it is a transformation of two whole systems. While problems at this stage may seem to be primordial among partners, they may also reflect a failure in separation from home families or an extreme departure that places too much pressure on the couple. Families with young children need to adapt to new conditions, cooperate in solving childcare tasks, avoid marital couples being choked by paternity issues, and realign relationships with the extended family. Young parents are challenged to meet the children's needs for education and control, and work together as a team. This stage is extremely stressful for young mothers and is the life cycle phase with the highest rate of divorce (McGoldrick & Carter, 1999).

Parents who successfully deal with previous stages come to see their children turned into adolescents. Adolescence is the time when children no longer want to resemble their mom or dad, they want to be themselves, to discover their own individuality. They struggle to become autonomous and to break away from family boundaries. In this context, the challenge of parents is to tolerate and treat as much as possible the teenage separation and defining tendencies. If parents insist on controlling their adolescents as they were young children, they will cause escalations of the uprising, which is normal for this period (McGoldrick & Carter, 1999).

At the young age, parents must let their children go and see their own lives. This may be a liberating time for fulfillment, but it could also be the middle-of-life crisis (Nichols, 1987). Parents must not only solve the changes in the lives of their children, but also from their own lives, from the changes in their relationships with their own aging parents who need support.

Families in later life have to arrange their retirement, which means both the sudden loss of occupation and the sudden rise in the couple's approach. If both partners are at home, the house may suddenly seem a bit small. Later in life, families must take into account the decline in health, illness and then death Nichols & Schwartz, 2005)

A variation in the family life cycle that can no longer be considered a deviation is divorce. The primary tasks of divorced couples are to separate, but to maintain co-operation as parents. Many families after divorce become families with a parent, and the vast majority of them face financial difficulties. An alternative is remarriage and the formation of warm families, where loneliness often turns into conflict.

e. Looking after yourself and each other

Families do not live in isolation or in a vacuum. They include grandparents, aunts, uncles, friends, neighbors, other caregivers, co-workers and other adults who provide emotional support, information and practical help in various child raising activities and beyond (Harwood et al., 2010). The social network of a person is made up of important individuals for that person. Researchers

studying the impact of social networks distinguish between different types of social support that individuals within a social network can offer to a person (Cochran & Niego, 2002):

• *emotional support* refers to the expression of empathy and encouragement that inspires confidence and helps a person in a period of discouragement or worry;

• *instrumental support* is a form of practical help, usually in housework or in child care;

• *information support* refers to advice, information from people who have experienced or have more expertise in various fields;

• *the support of comrades* consists of opportunities for engaging in pleasant activities with other adults - for example, going to a movie or playing a game;

• *material support* refers to people who can provide financial support or other material support in difficult times (for example, offering a living space, useful items, a sum of money, etc.)

Parental social networking studies show that emotional support, counseling on raising children and helping them are particularly useful for young parents, especially when it comes to a single, divorced or separated parent (Cochran & Niego, 2002; Gringlas & Weinraub, 1995). In particular, women who say they have access to childcare support provided by social networking members have interactions with their own children with a higher positive load, are warmer with them emotionally and more sensitive to their needs.

Researchers have identified four ways in which social support is beneficial for families (Crockenberg, 1988). First of all, support can lessen the stress level in a parent's life. Babysitting, child raising tips, and material support provide relief for everyday hardships that might otherwise accrue, taking overwhelming proportions. A stressed parent is less likely to be an effective parent.

Another way social support helps to amortize the intensity with which the parent feels adverse effects or stressful events. A tough, frustrating day can be made to be more enjoyable in the company of a friend or family member who offers emotional support. Therefore, reducing stress in a parent's life improves the capacity to fulfill the role of parent in a competent way.

Social support also helps build effective coping strategies. For example, child behavioral problems, such as lack of respect or aggressive language, can create frustration for the parent. But if he talks with some work colleagues or neighbors, he realizes that such behaviors identify them to their children as well. In such circles of parents with common problems, the use of parenting strategies can be questioned in order to teach children to be more cooperative and respectful. Thus, parents who receive emotional support from others have the sign that people care about them, and this has the effect of increasing the capacity to encourage others, including their own children. In addition, research has shown that parenting access to rich and satisfying social networks can be limited by socio-economic factors, such as family income, parental education experiences and professional level (Harwood et al., 2010).

Parents' access to positive social networks has been associated with many beneficial effects in the development of children, including well-being and family happiness, better social skills in dealing with same-age people, the development of solid friendship with other children (Cochran & Niego, 2002). Also, children benefit from both emotional and cognitive benefits from regular contacts with members of a receptive network and on which they can rely. Thus, adult members of the network can provide children with exits (visits to the zoo, park, cinema, etc.) as well as opportunities to engage in everyday activities such as gardening or cooking - all in the context of a warm, caring (Harwood et al., 2010).

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3. Psychological wellbeing

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Chapter summary

This chapter will bring into attention the topic of wellbeing as an important resource for living a happy and healthy life. There are presented two important theoretical models which conceptualizes the concept of wellbeing so that we could figure out also what are the implications for the ordinary life. In the section Quizzes there are more scales and practical applications which could enhance the parents' perception upon their own level of wellbeing.

Glossary/Words to know/Definitions

Wellbeing, Psychological wellbeing, Positive emotions, Engagement, Meaning, Positive relationships, Self-compassion

Theoretical section on the topic of our specific

The **Psychological Wellbeing** is a term very wide known as similar with positive mental state or happiness, or subjective wellbeing. There are many conceptualization for the term, but we will consider two main models and we will present the factors which contribute to the developing and maintaining the psychological wellbeing.

Martin Seligman a very well-known psychologist and the promoter of positive psychology developed a wellbeing model, PERMA, which comprises five dimensions addressing both hedonic and eudemonic kinds of happiness.

Seligman believes that PERMA model could contribute to the better life of people, enriching their happiness, social life and meaning.

The five elements are: (P) Positive emotions, (E) Engagement, (R) Positive Relationships, (M) Meaning and (A) Achivement.

1. *Positive emotions*

Positive emotions are mostly connected to happiness, and we all think about joy and happiness when we are talking about wellbeing. But it is not only about feeling positive emotions, it is also about a positive regard upon things and life, it is about an optimistic point of view upon past, present and the future. This positive view could help in establishing healthy relationships, in involving plenary in work, alleviating the depressive moods and increasing positive expectations. This bring out the benefits of optimism in all tasks and dimensions of life.

Barbara Fredrickson, (1998; 2004) an American researcher developed the *The broaden-and-build theory of positive emotions* which demonstrates "what good are positive emotions." According to her theory, positive emotions appear to broaden peoples' momentary thought–action repertoires and build their enduring personal resources; positive emotions also facilitate behavioral tendencies. Fredrickson (2009) suggests that with positivity, people are able: to see new possibilities, to bounce back from setbacks, to connect more deeply with others, and reach their potential. If we try to explain the broaden effects of positive emotions we could find out that positivity expands our outlook by broadening our field of peripheral vision has been confirmed in numerous other studies (Fredrickson, 2008; Rowe, Hirsh, & Anderson, 2007; Schmitz, De Rosa, & Anderson, 2009; Trick, Brandigampola, & Enns, 2012). Increased positive emotion has also been found to facilitate a greater sense of connectedness with others; a temporary boost in positivity allowed people to see more overlap between themselves and others, leading them to conclude that with positivity, people feel closer and more connected to the important people in their lives. The positivity broadens social responses by expanding an individual's circles of trust (Dunn & Schweitzer, 2005), by forming common in-group identities reducing the distinction between "them" and "us" (Dovidio, Isen, Guerra, Gaertner, & Rust, 1998) and overcoming own-race bias (Johnson & Fredrickson, 2005).

Fredrickson (2009) contends that positivity does not just change one's bad thoughts for good ones, **it changes the scope and boundaries of one's mind** thereby impacting performance. Importantly, these changes have also been found to positively impact performance in the workplace. A broadened mindset is the basis for **discovery**, discovery of new **knowledge**, new **alliances** and new **skills** (Fredrickson, 2013a). These resources can emerge in several different forms, including cognitive (e.g., expert knowledge, intellectual complexity), social (e.g., friendships, social support networks), psychological (e.g., resilience, optimism), and physical (e.g., health, longevity) outcomes. Rather than merely signaling optimal functioning, enhanced resources can actually help to generate intrapersonal, interpersonal, and organizational growth (Lyubomirsky et al., 2005; Mauss et al., 2011; Vacharkulksemsuk et al., 2011). In 2005, Losada and Fredrickson collaborated to explore the impact of positive to negative affect (P/N ratio) that distinguishes between a flourishing and non-flourishing state in individuals (Fredrickson & Losada, 2005). They found a report of 3 to 1 from positivity to negative state (such as we need three positive experiences to counteract one negative experience) Fredrickson discovered ten positive emotions which are considered having a great impact on human lives.

Emotions	Impact and benefits
Joy	Joy emerges when one's current circumstances present unexpected good fortune. It creates the urge to play and get involved and allows us to accrue skills gained through experimental learning
Gratitude	Gratitude emerges when people acknowledge another person as the source of their unexpected good fortune. It creates the urge to creatively consider new ways to be kind and generous and builds the skills for showing care, loyalty, and social bonds

Serenity	Also called contentment, serenity emerges when people interpret their current circumstances as utterly cherished, right, or satisfying. It creates the urge to savor those current circumstances and integrate them into new priorities or values.
	Interest arises in circumstances appraised as safe but offering novelty. It creates the urge to explore, to learn, to immerse oneself in the novelty and thereby expands the self.
Hope	Hope arises in dire circumstances in which people fear the worst yet yearn for better. It creates the urge to draw on one's own capabilities and inventiveness to turn things around and builds the resources of optimism and resilience.
Pride	Pride emerges when people take appropriate credit from some socially valued good outcome. It creates the urge to fantasize about even bigger accomplishments in similar arenas and leaves us feeling confident and self-assured.
Amusement	Amusement occurs when we appraise our current circumstances as involving some sort of non-serious social incongruity. It creates urges to share a laugh and find creative ways to continue the joviality helping us to build and solidify enduring social bonds.
Inspiration	Inspiration arises when people witness human excellence in some manner. It creates the urge to excel oneself, to reach one's own higher ground or personal best and builds the motivation for personal growth
Awe	Awe emerges when people encounter goodness on a grand scale. The experience of awe compels people to absorb and accommodate this new vastness they have encountered and creates new worldviews.
Love	Love, which appears to be the positive emotion people feel most frequently, arises when any other of the positive emotions is felt in the context of a safe, interpersonal connection or relationship. It creates momentary perceptions of social connection and self-expansion and builds social bonds and community.

2. Engagement

The engagement is the type of state which put us in a continuous and active state of mind, absorbed by something we like to do or to experience. All the people need something in their lives to be kept into a present moment, creating a "flow" into the specific activity. Seligman consider this type of flow as an important factor for activate the intelligence, skills and emotional capabilities.

Flow (Csikszentmihaly, 2000) describes an experiential state of deep absorption in the present moment that is intrinsically rewarding, promotes growth, and can give value and meaning to one's experiences, thus increasing eudaimonic well-being. Mihaly Csikszentmihaly suggests that people experience an extreme form of well-being when engaged in highly challenging tasks, but their resources and skills must be equal to the challenge of that task. Flow, or optimal human experience occurs when people have a clear goal, an appropriate level of challenge that matches their strengths to the tasks they're undertaking, and regular feedback. Flow lead us to be more involved in life, to enjoy activities, to have a sense of control, and to feel a strong sense of self (Lyubomirsky, 2007), thus increasing positivity in individuals.

Some effects of flow state of mind:

- intense and focused concentration on what one is doing in the present moment,
- merging actions and awareness,
- loss of reflective self-consciousness,
- a sense that one can control one's actions,
- distortion of temporal experience,
- and experiencing the activity as intrinsically rewarding

3. Relationships

It is scientifically proved that relationships and connections are some of the most important aspects of life. There is a longitudinal study which demonstrated that a close relationships is guaranteeing happiness and a fulfillment in life. Social connections are origin for a healthy development for all human beings. Positive relationships with relatives bring out joy and love in humans' life and give the security feeling of belonging and support for difficult times. Relationships prevent isolation which is considered very dangerous for the healthy life. Having close relationships with siblings, parents, friends become a strong protective factor facing any difficulty.

Social awareness is considered the behavioral range that runs from instantly sensing the inner state of other people, to understanding their feelings and thoughts, to comprehending the meaning and significance of complicated social situations. It comprises: *Primal Empathy:* To sense the non-verbal emotional signals of others and to feel what they are feeling; *Attunement:* To attend and attune to others with a sustained receptivity that leads to rapport; *Empathetic Accuracy:* To consciously and accurately understand another person's thoughts, feelings, and intentions; *Social cognition:* Knowing how the social world works. Social cognition emerges out of the development of primal empathy, attunement, and empathetic accuracy.

Empathy is one of the most effective and deeply rooted skills we have for connecting with other people; it's the ability to step into the shoes of another person, aiming to understand their feelings and perspectives, and to use that understanding to guide our actions. It is the ability to "know another person's inner experience" (Buie, 1981, p. 282), the ability to "feel (perceive) the feelings (emotions) of other people" (Sawyer, 1975, p. 37). We could distinguish from two kinds of empathy:

- *cognitive empathy* - the ability to see the world through others' eyes. Cognitive empathy is mind-to-mind, giving us a mental sense of how another person's thinking works
- *emotional* empathy- with emotional empathy we feel what the other person does in an instantaneous body-to-body connection

If we are curious to find out what research is saying, we could show some answers:

- empathic people tend to be more generous and concerned with others' welfare,
- they tend to have happier relationships and greater personal well-being.
- Empathy can improve leadership ability
- Empathy can facilitate effective communication.
- people who are empathetic may feel that they are kind toward others and are doing something good for others, both of which may bring these individuals happiness and positive feelings.
- Therefore, empathy toward others is likely to be associated with increases in one's satisfaction with life, happiness, and positive affect.

Six Habits of Highly Empathic People (***Roman Krznaric, Ph.D.)***
Habit 1: Cultivate curiosity about strangers
Habit 2: Challenge prejudices and discover commonalities
Habit 3: Try another person's life
Habit 4: Listen hard—and open up

Habit 5: Inspire mass action and social change
Habit 6: Develop an ambitious imagination

4. Meaning

Meaning make the difference from a life full of pleasure (positive emotions) and a life meaningful. It is demonstrated that people need a meaning to live their lives (Frankl,1985) as a greater purpose to life. Wellbeing is not mainly derived from "feeling good" but from "doing good", and the meaning is the core engine of initiatives which conduct to happiness.

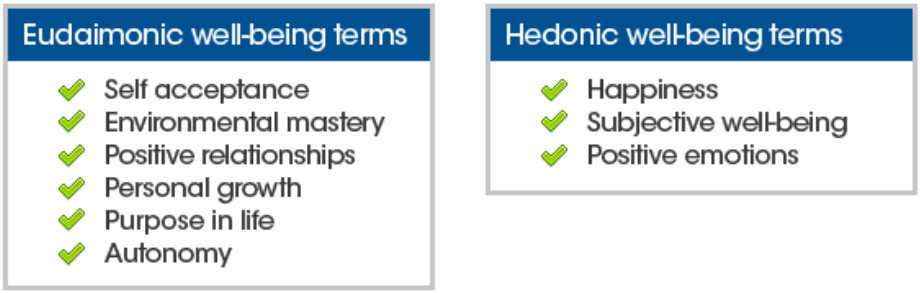
The presence of meaning in life is broadly defined as the subjective experience that one's life is significant and valuable (Steger, Frazier, Oishi, & Kaler, 2006). Erikson argues that people enter the developmental period of generativity vs. stagnation. During this stage, people struggle to find a way to contribute and give back to the world. Generative adults dedicate themselves to activities that will outlive the self and successfully find ways to contribute to the next generation (Kotre, 1984; McAdams, de St. Aubin, & Logan, 1993).

Martin Seligman defines the meaningful life as knowing what your highest strengths are and "using your signature strengths and virtues in the service of something much larger than you are." He comments that *authentic happiness* is meant "as a preface to the meaningful life and that while it is possible take drugs to generate the effects of positive emotion and pleasure through pharmacology, it is not possible to synthesize the positive effects of being in the flow or of experiencing meaning." Meaningful life consists in attachment to something bigger than you are. Meaning is knowing what your highest strengths are - and deploying those in the service of something you believe is larger than you are. Meaning comes from serving a cause bigger than ourselves. Whether this is a specific deity or religion, or a cause that helps humanity in some way, we all need meaning in our lives to have a sense of well-being.

5. Accomplishments

Accomplishments come after a goal is met so the person could experience satisfaction and the sense of fulfillment. This dimension corresponds to the highest level of needs' pyramid, the people need to fulfill their own potential. Having accomplishments in life is important to push towards flourishing and thriving.

The second approach on wellbeing is more focused on eudaimonic aspects and it is developed by Carol Ryff, a researcher from University of Wisconsin.



CAROL RYFF - multidimensional model of WELLBEING

This model is composed by 6 different dimensions: Self-acceptance, Positive relations with others, Autonomy, Environmental mastery, Purpose in life and Personal growth.

SELF-ACCEPTANCE: it means the positive opinion a person has of himself. It does not refer to narcissistic self love or superficial selfesteem, but instead to a constructed self-regard that includes both positive and negative aspects [Ryff and Singer, 2003].

AUTONOMY: This refers to a person‘s ability to march to his own drum and to pursue personal convictions and beliefs, even if these go against accepted dogma or conventional wisdom. It also refers to the ability to be alone if necessary and to live autonomously [Ryff and Singer, 2003].

ENVIRONMENTAL MASTERY: This is another essential factor in well-being and concerns the challenge of a person mastering the environment around him. This ability requires the skills of creating and sustaining environments that are beneficial to a person [Ryff and Singer, 2003]. The ability of an individual to choose or to create environments appropriate for his mental state is defined as a characteristic of mental health.

PURPOSE IN LIFE: This is a person‘s ability to find a meaning and a direction in his own experiences, and to propose and set goals in his life [Ryff and Singer, 2003]. The definition of maturity also clearly emphasizes an understanding of the purpose of life and the presence of a sense of direction and intentionality. A positively functioning person has goals, intentions and a sense of direction, and all of this helps to give a meaning to life [Ryff and Singer, 1996].

PERSONAL GROWTH: This factor concerns a person‘s ability to realize his own potential and talent and to develop new resources. It also frequently involves encounters with adversity that require one to dig deeply to find one‘s inner strength [Ryff and Singer, 2003]. It is associated with being open to new experiences, which is a key characteristic of the fully functioning person.

SELF-COMPASSION is a recent concept developed by Kristin Neff and defined as the ability of quieting one's inner critic and replacing it with a voice of support, understanding, and care--in other words, treating yourself with the same kindness and support that you show to other people. Trying to identify what the experience of compassion feels like, the answers could be: 1. to have compassion for others you must notice that they are suffering; 2. compassion involves feeling moved by others' suffering so that your heart responds to their pain (the word compassion literally means to "suffer with"); 3. Having compassion also means that you offer understanding and kindness to others when they fail or make mistakes, rather than judging them harshly; 4. when you feel compassion for another (rather than mere pity), it means that you realize that suffering, failure, and imperfection is part of the shared human experience. "There but for fortune go I."

There are three elements of self-compassion:

1. Self-kindness vs. Self-judgment - it refers of being warm and understanding toward ourselves when we suffer, fail, or feel inadequate vs. ignoring our pain or flagellating ourselves with self-criticism.

2. *Common humanity vs. Isolation.* – it refers of recognizing that suffering and personal inadequacy is part of the shared human experience vs. being something that happens to "me" alone.

3. *Mindfulness vs. Over-identification* –Mindfulness is a non-judgmental, receptive mind state in which one observes thoughts and feelings as they are, without trying to suppress or deny them vs. not be "over-identified" with thoughts and feelings, so that we are caught up and swept away by negative reactivity.

Self-compassion is associated with:

• Lower level of anxiety and depression (Neff, 2003)

• Lower levels of cortisol (stress hormone) and increased heart-rate variability for self-soothing (Rokliff et al., 2008)

• Less rumination, perfectionism and fear of failure (Neff, 2003; Neff at al., 2005)

• Better coping with stressors like academic failure, divorce, childhood maltreatment, or chronic pain (Sbarra et al., 2012; Vettese et al., 2011; Costa & Pinto-Gouveia, 2011)

• Greater willingness to validate their negative emotions, lower likelihood to suppress them (Leary et al,. 2007; Neff, 2003)

Self-compassion is associated with positive psychological strengths like: Wisdom, Curiosity and exploration, Happiness, Optimism, Personal initiative, Emotional intelligence. It is also associated with: improved relationships (Neff & Beretvas, 2013); more empathy, altruism, perspective taking and forgiveness (Neff &Pommier, 2012); health related behaviors.

What research say?

It would be interesting to see what the relations of wellbeing with other socio-demographic factors are. The researches show well-being is not determined by any single factor, but has a multidimensional character [Martire, Stephens and Townsend, 2000]. Culture and personal influence have been shown to have an important effect on well-being. Well-being can vary greatly in relation to age, gender and culture. Some authors, such as Ryff and Keyes [1995] consider that elderly people experience less personal growth, and also suggest that mastering the environment and autonomy increase as people reached the older stages of life. It has already been described how psychological well-being can be positively related to factors such as satisfaction with life and self-concept or self-esteem. Several studies have assessed the differences in psychological well-being and self-concept between the genders, although the different measures used and the discrepancies between the results obtained make it difficult to draw any clear conclusions.

Another aspect with important repercussions on psychological well-being is socioeconomic situation, which includes some objective conditions such as access to housing, a healthcare system, education, employment and recreational activities [Diener, 2000] The research by Ryff [2001] on the impact of economic level on the degree of well-being showed a clear relationship between socioeconomic level and some dimensions of well-being, such as self-acceptance and personal growth. In relation to this socio-demographic variable, it was found that being part of a family situation with equal status in the decision-making and a good conjugal relationship had a favorable overall influence on health and psychological well-being. The results of the study by Escriba-Agüir and Tenias-Burillo, 2004] confirm this, and show that a good relationship with one‘s partner improves psychological well-being. Well-being is clearly influenced by social contact and interpersonal relationships. It has also been shown to be associated with contacts in the community and active patterns of friendship and social participation [Blanco and Diaz, 2005. There is also an association between well-being and positive relationships with others.

Quizz

Here you could find some quizzes, scales to identify your level of wellbeing.

Personal self-evaluation The Positive and Negative Affect Schedule (PANAS; Watson et al., 1988 - PANAS Questionnaire

This scale consists of a number of words that describe different feelings and emotions. Read each item and then list the number from the scale below next to each word. Indicate to what extent you feel this way right now, that is, at the present moment OR indicate the extent you have felt this way over the past week (circle the instructions you followed when taking this measure)

- 1 -Very Slightly or Not at All
- 2 - A Little
- 3 - Moderately
- 4- Quite a Bit
- 5 - Extremely

_____ 1. Interested	_____ 11. Irritable
_____ 2. Distressed	_____ 12. Alert
_____ 3. Excited	_____ 13. Ashamed
_____ 4. Upset	_____ 14. Inspired
_____ 5. Strong	_____ 15. Nervous
_____ 6. Guilty	_____ 16. Determined
_____ 7. Scared	_____ 17. Attentive
_____ 8. Hostile	_____ 18. Jittery
_____ 9. Enthusiastic	_____ 19. Active
_____ 10. Proud	_____ 20. Afraid

If you are interested in finding out how to generate positive emotions, here is an exercise: **Best Possible Self**

Take a moment to imagine your life in the future. What is the best possible life you can imagine? Consider all of the relevant areas of your life, such as your career, academic work, relationships, hobbies, and/or health. What would happen in these areas of your life in your best possible future? For the next 15 minutes, write continuously about what you imagine this best possible future to be.

Use the instructions below to help guide you through this process.

1. It may be easy for this exercise to lead you to examine how your current life may not match this best possible future. You may be tempted to think about ways in which accomplishing goals has been difficult for you in the past, or about financial/time/social barriers to being able to make these accomplishments happen. For the purpose of this exercise, however, we encourage you to focus on the future—imagine a brighter future in which you are your best self and your circumstances change just enough to make this best possible life happen.

2. This exercise is most useful when it is very specific—if you think about a new job, imagine exactly what you would do, who you would work with, and where it would be. The more specific you are, the more engaged you'll be in the exercise and the more you'll get out of it.

3. Be as creative and imaginative as you want, and don't worry about grammar or spelling

SELF-COMPASSION SCALE–Short Form (SCS–SF) (http://self-compassion.org/wp-content/uploads/2015/02/ShortSCS.pdf) (Raes, F., Pommier, E., Neff,K. D., & Van Gucht, D.

(2011). Construction and factorial validation of a short form of the Self-Compassion Scale. Clinical Psychology & Psychotherapy. 18, 250-255.)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

- Almost never 1 2 3 4 5 Almost always

  _____1. When I fail at something important to me I become consumed by feelings of inadequacy.

  _____2. I try to be understanding and patient towards those aspects of my personality I don't like.

  _____3. When something painful happens I try to take a balanced view of the situation.

  _____4. When I'm feeling down, I tend to feel like most other people are probably happier than I am.

  _____5. I try to see my failings as part of the human condition.

  _____6. When I'm going through a very hard time, I give myself the caring and tenderness I need.

  _____7. When something upsets me I try to keep my emotions in balance.

  _____8. When I fail at something that's important to me, I tend to feel alone in my failure

  _____9. When I'm feeling down I tend to obsess and fixate on everything that's wrong.

  _____10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.

  _____11. I'm disapproving and judgmental about my own flaws and inadequacies.

  _____12. I'm intolerant and impatient towards those aspects of my personality I don't like.

Coding Key:

- Self-Kindness Items: 2, 6
- Self-Judgment Items: 11, 12
- Common Humanity Items: 5, 10
- Isolation Items: 4, 8 Mindfulness Items: 3, 7
- Over-identified Items: 1, 9

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3, 4 = 2, 5 = 1) - then compute a total mean.

SATISFACTION WITH LIFE SCALE (Ed Diener, Robert A. Emmons, Randy J. Larsen and Sharon Griffin)

Below are five statements that you may agree or disagree with. Using the 1 - 7 scale below, indicate your agreement with each item by placing the appropriate number on the line preceding that item. Please be open and honest in your responding.

- 7 - Strongly agree
- 6 - Agree
- 5 - Slightly agree

- 4 - Neither agree nor disagree
- 3 - Slightly disagree
- 2 - Disagree
- 1 - Strongly disagree

_____ In most ways my life is close to my ideal.
_____ The conditions of my life are excellent.
_____ I am satisfied with my life.
_____ So far I have gotten the important things I want in life.
_____ If I could live my life over, I would change almost nothing.

- 31 - 35 Extremely satisfied
- 26 - 30 Satisfied
- 21 - 25 Slightly satisfied
- 20 Neutral
- 15 - 19 Slightly dissatisfied
- 10 - 14 Dissatisfied
- 5 - 9 Extremely dissatisfied

Resources for parents

Helpful Websites
https://www.happilyfamily.com/
https://www.habitsforwellbeing.com/perma-a-well-being-theory-by-martin-seligman/
http://www.pursuit-of-happiness.org/history-of-happiness/martin-seligman-psychology/
http://self-compassion.org/

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4. Strategies for Fostering Wellbeing within Family

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The approach to Well-being, in general, and in the family, in particular, makes us think about both Alma-Ata Declaration and Ottawa Charter (21st November 1986) on Health Promotion. This is a charter of intent that declares health as a resource and not as an end to be achieved, outlining the promotion of health as any action that aims to enable citizens to intervene in order to achieve better health. In other words, the innovation of the sense of action in health promotion lies in the right and duty of self-affirmation, pro-activity, responsibility and entrepreneurship, centered not only on the individual but on all the health agents. This means, on the one hand, that to achieve a complete state of wellbeing, individuals or groups must be able to identify and fulfill their aspirations and meet their needs in order to modify or adapt themselves to the environment, and, on the other hand, that Health Promotion is understood as a process that aims to increase the capacity of individuals and communities to control their health.

The Portuguese National Health Plan 2011-2016 (2010, p.7) seeks to understand the current and complex social requirements by considering the technical and scientific development. In addition, it also aims to establish strategies and goals that allow "to maximize the health gains of the population through the alignment and integration of sustainable efforts of all sectors of society, with a focus on access, quality, healthy policies and citizenship.

The Health 2020 Strategy also emphasizes the role of healthy environments and resilient communities in achieving health gains and reducing health inequalities. The actions to be undertaken should consider the relevance of the environment to health in general and throughout the individual and family life cycle, as well as specific environments, taking into account environmental or occupational factors. (DGS, 2015).

In a more specific way, the Directorate-General for Health is also aware of the need for a direct and targeted intervention on the mental health of this population (vulnerable individuals and families). Thus, in the executive summary of the National Mental Health Plan 2007-2016 (2008, p. 63) arises the premise of "ensuring equitable access to quality mental health care for all people with mental health problems in the country, including those belonging to particularly vulnerable groups; (...) to reduce the impact of mental disorders and to contribute to the promotion of the mental health of populations; (...).

The DGS (2012) also argues that it is important to promote health-friendly environments throughout the life cycle and recognizes that health does not accumulate, but results from a history of health promotion and disease prevention and its complications and from the adoption of healthy behaviours and experiences in healthy environments. Health losses can have a cumulative effect throughout life. In this context, it also highlights the opportunity for early intervention in risk factors, essential for the prevention of chronic diseases and complications, by screening, early diagnosis and promotion of therapeutic adherence, as well as by the rehabilitation and/or integration of the person with functional limitations. Bearing in mind that the individual health pathway is not constant, it has specific needs and particularly important moments, called critical periods, which, by the way they occur, directly influence in a positive or negative way the subsequent stages in life. The intervention at these moments - considered windows of opportunity - promotes and protects health and wellbeing and may have high relevance in the medium and long term (DGS, 2012).

Thus, family wellbeing presupposes the satisfaction of the needs that arise throughout the life cycle. Interventions should be based on life-cycle approaches and on settings, facilitating an integrated understanding of the range of health problems that should be prioritized for different age groups, in the different social roles that citizens assume throughout life on different settings (DGS, 2015).

Family members need clear and accurate information about the disability, its needs, potentialities and limitations, which should be encouraged about its relevant role for the development and rehabilitation of the disabled person (Sólcia, 2004). It follows that parents must have literacy levels adjusted to their needs, in order to understand the information provided by the technicians. For many years, literacy has been recognized as a human right in several international initiatives. In 2016 the European Declaration of the Right to Literacy was published, defining eleven essential conditions for implementing this basic right to literacy. We highlight four of them that reveal how important the family context is in the enjoyment of this right:

- Young children should be encouraged to learn language and literacy at home.
- Parents should get support in order to help their children to learn language and to acquire literacy, by providing them with accessible guidance and, when necessary, family literacy programs.
- Adults should be supported in the development of the literacy skills necessary to participate fully in society.
- Policymakers, professionals, parents and communities must work together to ensure equal access to literacy, bridging the gaps existing in the social and educational plans (Greef, Hanemann, Hammink, Mallows, & Nascimbeni, 2016).

Now, if this is important in most families, it becomes more important for families with children with Special Needs, where they themselves have special needs, special experiences and special motivations in order to achieve better conditions of wellbeing. The concept of **emergent literacy** has arisen recently among the various types of literacy, which underlies that everyone is

prepared to learn something and that exists an appreciation of all knowledge, even of the most elementary, as an important point of support for any learning. Hence, it appears that emerging literacy does not lie exclusively in language, but in the process that underlies it (Mata, 2006). This author considers emerging literacy as a process that is based on eight vectors: Cultural process (... process of integration in the multiform world); Social process (dependent on the ability of others to involve the child in literacy activities); Conceptual process (the signs that the child makes are full of meaning in every way); Early and continuous process; Active and participatory process (subjects construct and reconstruct their own conceptual hypotheses); Contextual and meaningful process (opportunity to explore and gain the sense of belonging); Functional process (language is easy to learn whether it fulfils a functional need); Affective process (it is from the affective characteristics of the initial contacts with the writing that they will develop more or less positive attitudes and consequently with more taste and pleasure).

a. Self-esteem and Self-confidence of Parents with Disabled Children

Families, as the first context of socialization, play a fundamental role in children's behaviour and development (Baumrind, 1991; Parke & Buriel, 2006). Early relationships have been identified as key to the development of the child (Baumrind, 1978; Bornstein, 2002, 2006; Maccoby, 2000; Sroufe, 2000), and the quality of parental care is often singled out as the most important variable for child development (Sroufe, 2002). Family has a major role in the maturity and biopsychosocial development of individuals, presenting some primary functions that can be grouped into three categories that are closely related: biological (survival of the individual), psychological and social functions (Osório, 1996). As for the psychological functions, we can mention three groups:

a) to provide affection to the newborn, key aspect to ensure the emotional survival of the individual;

b) to support humans in situations of existential anxiety during their development, by assisting them to overcome the "vital crises" through which all humans pass throughout life (an example of a crisis that can be mentioned here is the adolescence);

c) to create an appropriate environment that allows the empirical learning that sustains the cognitive development process of humans (Osório, 1996).

According to Romanelli (1997), the family corresponds to a privileged place of affection, in which are inserted intimate relationships and the expression of emotions and feelings. Therefore, it can be said that it is within the family that the individual maintains his initial interpersonal relationships with significant people, establishing emotional exchanges that act as an important emotional support when individuals reach adulthood. These lifelong emotional exchanges are essential for the development of individuals and for the acquisition of central physical and mental competencies for each stage of the psychological development.

Studies suggest that the family still keeps its specific role in the social context in which it is inserted. At the micro-social level, the family continues to play a central role throughout the development process of its members, performing particular functions at each stage, although changes have been observed in terms of the intensity with which these functions are exercised in contemporaneity (Nogueira, 1998).

In view of these arguments, it is imperative to invest in parent orientation programs to enable them to better cope with their adolescent children, helping parents to acquire more precise guidelines that serve as a reference for adolescents when facing situations that require reflection and decision-making. Psychology has shown concern by studying the influence of the environment on the development of an individual, being the parental behaviour the research target of many researches with relevance for the understanding of human development and its (in)adaptive functioning (Canavarro & Pereira, 2007). Pereira, Canavarro, Cardoso and Mendonça (2009) mention several studies that suggest that the negative behaviours of parents can increase the risk of adjustment of their children. The same authors suggest that the relationship between parents and children plays a central role in understanding their behavioural and psychosocial development. For Canavarro (1996) parents are often seen as key players in the development of children, in the same way that the family becomes their main context of socialization. Subsequently, this will contribute to the formation of the identity of the subject that is dependent on the social, intellectual and emotional development that results from the established family relationships.

One of the fundamental aspects for the development of self-esteem is the recognition that the parents express to children by their behaviours. Self-esteem can only develop from the person's participation in social contexts, being this development proportional to the capacity that the social environment (parents, family, etc.) has to provide positive reinforcement for their members (e.g. children). It is maintained and developed by the person himself, as she learns self-recognition from others and observes their behaviours and the positive reinforcements they produce. Self-esteem is a basic need (Maslow, 1968) of the human being and it acts as the propellant that makes us to overcome the challenges and build a peaceful inner world. It is an achievement that is produced throughout life according to the relationships that the subject builds, feeling himself loved and fulfilled, thus ensuring a good emotional balance. Self-confidence refers to the feeling of personal competence.

The pillars of self-esteem are built up early in the life of the human being. Children acquire their self-esteem through the relationships they establish with people in their daily lives. Thus, it is important that families provide conditions for children to build good self-esteem through valorisation and self-respect.

High self-esteem helps man to take risks, to be creative, to learn new skills and to be more productive, taking advantage of the maximum potential of each one, contributing to the improvement of family and organizations and, consequently, of society.

According to Mack R. Douglas, (1998, p.189): "In order to have high self-esteem, the child needs parental approval from the first days of life and throughout the life cycle. This includes the perception of his personality, his sense of ability and individuality. "

A healthy environment that enables the development of children is that which provides support when necessary and allows independence, choice of options; allowing the child to observe secure and consistent references and to be aware of his possibilities.

b. Self-management (emotion regulation, self-control)

The ability of self-management/self-regulation is reflected in Daniel Goleman's (2003) theory on Emotional Intelligence (EI). The author defines EI as the ability to manage our emotions in order to deal effectively with life situations.

EI is a set of skills or attitudes that include, for example, keeping intense emotional reactions under control, being driven by achieving goals, understanding others and being flexible when faced with changes or new situations, among others. Thus, the same author decomposes the components of (EI) into five fundamental dimensions: **Self-awareness/self-knowledge** (to know me), ability to recognize your own emotions and how they affect your thoughts and behaviour, to know your strengths and weaknesses, and to have self-confidence; **self-control/self-regulation, self-management** (to manage me), ability to control impulsive behaviours and feelings, to manage your own emotions in a healthy way, to take initiative, to fulfil commitments and to adapt to changing circumstances; **self-motivation** (to mobilize me); **social skills** (ability to understand other people's emotions, needs and concerns, to capture the emotional signals of others, to feel comfortable in social situations), and **Empathy** (to understand others, knowing how to put yourself in the place of others in order to understand them, to perceive others' feelings through their body language, to have consideration for others' points of view, needs and/or interests) (Goleman, 2003).

We can thus subdivide EI into intrapersonal intelligence, which adds the dimensions of self-consciousness, self-regulation and self-motivation; and interpersonal intelligence, that aggregates the dimensions of empathy and social aptitude.

Therefore, Self-control/self-regulation/self-management integrates the EI competency map, constituting the dimension of "I manage myself". Self-control skills help us to keep our balance when facing life's challenging situations, such as changes and events that destabilize us, and to be seen as people who manage the job well. **Self-control** is about keeping intense emotional reactions under control. We can observe that the person who evidences this competence demonstrates the following characteristics/indicators: It dominates emotional outbursts and impulsive actions; Contains the expression of feelings when they are not adequate; Can think clearly in situations of pressure.

EI is the basis of personal development. It is the ability to deal adaptively with our emotions, to recognize one's own and others' emotions, and the ability to manage one's own and others' emotions, constituting a "dance" between our rational brain and our emotional brain. The intersection between both brains and their interaction is what constitutes the EI.

The stress in personal and family life and the negative events that arise throughout our life cycle require self-regulation and social and emotional self-control, that if we do not train, if we do not work those skills, will produce devastating results.

c. Positive thinking / Positive Psychology

The movement denominated "Positive Psychology" appeared officially in the United States in 1997/1998, from the initiative of Martin E. P. Seligman (psychologist and professor at the University of the Pennsylvania in the United States) that, in team with other researchers, initiated a set of researches with the ultimate goal of promoting a change in the focus of psychology. As professor of psychopathology, at some point in his clinical practice, he wondered about the frequent tendency of psychology to focus its studies on diseases, on dysfunctional aspects, without however emphasizing the positive aspects of human development.

From 1997 onwards, Seligman became president of the American Psychological Association (APA), and his research began to be disseminated worldwide. It is considered that from the 1990s his questions began to give rise to Positive Psychology. Thus, a "new" research paradigm emerged, where a change of focus could be observed - from the negative to the positive -, emphasizing the construction of positive qualities or virtues (Seligman & Csikszentmihalyi, 2000; Snyder & Lopez,

2009). In this sense, Positive Psychology starts to address the positive functioning of personality, subjective wellbeing and teaching of resilience, where emotions and feelings play a crucial role in how people react to the circumstances of the various ecological contexts (Bronfenbrenner, 2009).

This branch of psychology is dedicated to the study of positive emotions (happiness, pleasure), positive traits of character (wisdom, creativity, courage, citizenship, etc.), positive relationships (friendship, trust, healthy affective bonds) and positive institutions (schools, companies and communities).

In contrast with the approach of traditional psychology, which focuses on the study and treatment of disorders such as depression and anxiety, the field of action and intervention of Positive Psychology (PP) is intended to focus more on strength rather than weaknesses. It also integrates the premise that believes in the power of activities that promote psychic wellbeing and, consequently, the way of seeing the world. Individual differences, which play an important role throughout this process, are also considered. In other words, positive psychology deviates from the tendency of clinical psychology to focus on pathology, placing the emphasis on the positive traits that make up our human repertoire.

The area of intervention of Positive Psychology focuses on understanding the "science and anatomy of happiness", positive experiences, **optimism** and altruism, pointing out to a view that psychological health is much more than the absence of symptoms. In this vision about the promotion of full mental health, we can include the following variables: **Satisfaction** (Living with joy, happiness and pleasure, having positive emotions). **Engagement** (to live the very best of you, to mobilize the strengths and virtues of your character). **Meaning** (to find a meaning in life (Mission, vision and values). **Relationships** (to build healthy relationships, with bond and mutual support).

Positive psychology is gaining ground within the social and behavioural sciences, considering, among others, aspects such as happiness, optimism and other positive emotions, its benefits and the strategies for developing them.

In this epistemological paradigm, the healthy and adaptive functioning of the human being is identified as the main object of study, being interested in the psychological traits and experiences considered positive, such as **optimism**, satisfaction, wellbeing, happiness, gratitude, hope, resilience or empathy. In this sense, Martin Seligman stresses the study of the "positive skills" of the human being, redirecting the focus to the promotion of quality of life.

Seligman has grouped the three pillars of PP:

- Positive states of **subjective wellbeing** (satisfaction with life, happiness, **optimism**);
- Positive individual/psychological traits (creativity, courage, compassion, integrity, wisdom, self-control, spirituality);
- Positive Institutions (healthy families, community, school, work environments, mass media).

How to define what is positive/good? Diener and Suh (1997) point out three guidelines to define "positive/good", defining this concept as "something that is chosen systematically, which is seen as a source of satisfaction (whether an object, event, process or outcome)."

The PP is based on the concept of resilience, as a deep capacity for overcoming crises in adverse situations. Resilience is often mentioned, by processes that explain the "overcoming" of crises and adversities in individuals, groups and organizations (Tavares, 2001; Yunes, 2001; Yunes & Szymanski, 2001). Walsh (1998) identifies as key processes of resilience: belief system; organizational patterns and communication processes.

In 1902, William James wrote about the "determination of the mind to be healthy" (James, 1964). Allport (1958) expressed interest in the positive features that incorporated the human repertoire. Maslow (1968) focused his study on the healthy person. Cowan (2000) developed research in the area of resilience on children and adolescents. In terms of intervention, positive psychology advocates that treating "is not just arranging what is damaged; it is also taking care of something or someone and fostering the best we have" (Seligman & Csikszentmihalyi, 2000). In this way, the forces are improved instead of correcting weaknesses, which has been one of the main PP objectives.

d. Positive Thinking/Optimism

We are told that human beings, when confronted with difficult, adverse or traumatic situations, experience a range of feelings that goes from anxiety, anger and depression to enthusiasm, strength and self-improvement. (Carver, Scheier, & Segerstrom, 2010). The balance between positive and negative feelings is strongly related to the differences between optimistic and pessimistic orientations in life.

For Seligman (1998, to be optimistic is related not only with having positive thoughts, but also with the way one thinks about the causes of negative events. The difference between optimists and pessimists lies in the way they explain the cause of negative or positive events that happen to them in everyday life, that is, their "explanatory style" (Peterson & Steen, 2002).

In general, we can therefore say that an optimistic person is one who sees difficulties as temporary, punctual, and does not blame himself for their occurrence. When confronted with a difficult situation, he perceives it as a challenge and strives to overcome it. On the other hand, a pessimistic person believes that negative events will endure and undermine all his actions, demonstrating a tendency to blame himself for such events (Scheier & Carver, 1992)

We found research that points out to the influence of optimism on the constitution of personality and positive indicators, such as self-esteem, which could result in differences in the physical and mental wellbeing. Optimism has been associated with better recovery outcomes in several areas of physical health (Zenger, Brix, Borowski, Stolzenburg, & Hinz, 2010).

The advantages of a positive thinking/optimistic orientation towards life also appear to be present in the domain of interpersonal relationships, since optimistic people, with their tendency to perceive life events as best as possible, end up involving more efforts to solving problems that keep relationships alive.

We can then consider that there is a number of empirical evidence showing that positive thinking/optimistic orientation towards life is strongly associated with greater subjective wellbeing, effective coping strategies, and greater care for health, work, and relationships. Being optimistic is a predictor of better physical and mental health, and of more adaptive resources in the face of adversity in the different areas of life (Scheier & Carver, 1992).

In this sense, the optimism variable can be associated to subjective wellbeing (SWB) evaluation. In addition to the resilience variable, SWB is a positive dimension of Health. At the same time, SWB is considered a complex concept that integrates a cognitive dimension and an affective dimension. It is a field of study that encompasses other concepts and domains: quality of life, positive affection and negative affection. Diener, Diener, & Diener (1995) define SWB as the evaluative reaction of people to their own lives, both in terms of satisfaction with it (cognitive assessment) and in terms of affection (stable emotional reactions, optimism).

The World Health Organization (2004) defines SWB as the feeling of comfort and harmony; satisfaction: as the feeling experienced when a goal is achieved, through the use and expansion of knowledge; and quality of life, according to the World Health Organization: as the individual's awareness about its position in life, in the context of culture and value system in which he live and in relation to his goals, expectations, standards and concerns.

Seligman reports in his studies that optimistic people have healthier attitudes and lifestyles and believe that their attitudes are important, unlike pessimists (Seligman, 1998, 2011; Seligman & Csikszentmihalyi, 2000). People with a high degree of satisfaction with life are more likely to be careful with their food, not to smoke and to practice regular exercise, thus presenting a more regular sleep.

Fredrickson (2001) mentions research that suggests that positive emotions promote longevity, individual and collective functioning, psychological wellbeing, and physical health.

He also argues that positive emotions promote physical, intellectual and psychosocial health, which lasts "long after the positive emotion has disappeared." This positive effect provides for increased resilience and optimism, which can help to "metabolize" the damaging effects of negative emotions on the mind and body.

The same author, in a study on unhappy couples, reveals that their interaction is predictable and rigid. In short, they have a monotonous/boring relationship. Happy couples, on the other hand, interact in an unpredictable way and accumulate a surplus of positive feelings toward the spouse. This suppresses aggression when they conflict.

Evidence considers positive emotions as protective factors against diseases, since, in a complex way, they strengthen the immune system (system responsible for protecting the body from any phenomenon that is foreign to it). People who regularly feel positive emotions are somehow driven by an "upward spiral" of continuous growth and fulfilment. They "become more useful to others" and can "turn communities into more cohesive, harmonious, and higher moral social organizations."

Positive emotions do not only have in common the widening of the momentary thought-action repertoires, but they also share the task of building personal resources, from physical and intellectual resources to social resources. Most importantly, these features tend to be enduring.

e. Problem-solving

For Gardner (1993), intelligence is defined as "the ability to solve problems or to develop products that are valued in one or more cultural or community environments."

Martin Seligman, the mentor of Positive Psychology, mentions the importance of teaching resilience, hope, optimism, in order to make man more resistant to depression and able to lead a happier and more productive life (Seligman, 1998, 2011). In this sense, our intervention should be guided by the adoption of activities that promote the training of optimism (hope of success instead of fear of failure, facing obstacles as circumvent circumstances, persisting in achieving goals rather than adversities); strategies to promote self-control and self-management (to create new perspectives, to increase the level of control over one's emotions, to develop energizing habits, to boost individual potential and skills, to understand the effects of behavioural positivity, to re-evaluate life goals and to develop action plans).

Positive thoughts enable us to use the frontal lobe by triggering the executive functions (*self-monitoring, self-regulation, planning, evaluation, and problem-solving*).

When we have the habit of thinking positively, the result is a general feeling of optimism, wellbeing and high self-confidence. Other benefits include personal growth, greater motivation, energy and joy of living, and a general sense of being fully experiencing the events of our lives.

f. Social-emotional learning within family

As mentioned in the previous chapters, the family has a strong and continuous influence on how the child develops. Family atmosphere, affective life, relationships between different family members and social relationships with other families contribute to the long educational trajectory throughout the life cycle. Education in the family context influences personality characteristics that contribute to the self-confidence and self-esteem of the child, cooperating for the construction of a complete human being. An educational process, where there are no restrictions and guidelines, can "dis-educate" rather than educate in a healthy way. Thus, the daily challenge is to find the balance between what can and should be allowed or forbidden. However, the school's contribution to human development, the promotion of socio-emotional competencies and the reduction of behavioural problems cannot be neglected (Barbosa, Santos, Rodrigues, Furtado, & Brito, 2011). Oliveira & Marinho-Araújo (2010) argue that family and school should be understood together due to the role they share in socialization and childhood education.

Bronfenbrenner (2009), in the bio ecological model proposed by him, argues that human development is a process of continuity and changes in the characteristics of people and groups that occurs throughout the life cycle and throughout the generations. In this model, the central concept revolves around the proximal processes that refer to the person's daily activities with other individuals, objects, and symbols in their immediate external environment, which become progressively more complex over time. For children, examples of proximate processes are the games they play among them, the school learning activities, the relationships with parents and teachers and sports practice.

These proximal processes are regarded as development drivers, and their strength and quality are influenced by the characteristics of the person, context and time (Bronfenbrenner, 2009). Thus, according to this model, the interaction of all these factors results in human development and can generate competence or dysfunction effects in the individual. The effects of competence result in the acquisition and subsequent development of intellectual, physical and social-emotional knowledge and skills. The effects of dysfunction result in the recurrent manifestation of difficulties in controlling one's behaviors in different situations (Bronfenbrenner & Morris, 2006).

In the United States, studies have been carried out that demonstrated that the proximal processes experienced in the family and in the school can act as protective factors for students facing individual or social adversities (Loukas, Roalson, & Herrera, 2010; Whittaker, Harden, See, Meisch, & Westbrook, 2011). For developing countries, such as Brazil, where there are a large number of children and adolescents in a situation of great vulnerability due to the enormous social and/or cultural inequalities (United Nations Children's Fund [UNICEF], 2012), these studies can also have an enormous social value (Diniz, Piccolo, Paula Couto, Salles, & Koller, 2013; Raffaelli, Koller, & Cerqueira-Santos, 2012). The study of different realities allows us to understand the facts and contributes to the elaboration of interventions targeted at the family and school context that aim at the integral development of children.

Whittaker, Harden, See, Meisch & Weatbrook (2011) studied the effect of factors present in families living in poverty in the United States on the development of socioemotional competence in

childhood, having concluded: that the contextual variables of risk, defined as the inadequacy of family resources and family conflict, influenced parental stress, which had a negative effect on the children; and that maternal sensitivity acted as a mediator in the relationship between parental stress and the social-emotional functioning of the children. From these results, Whittaker et al. (2011) concluded that the way parents respond to the needs of their children may play an important role in protecting them from the effects of adverse family processes such as parental stress. The same authors add that, although such risks had a negative influence on children's socioemotional competences, maternal high sensitivity acted as a protective factor, particularly in those that were most vulnerable to poverty.

However, we can't just to assign responsibilities to parental stress. Other researches have shown an association between: family climate and childhood characteristics, such as behavioural problems (Schultz & Shaw, 2003), social skills performance (Valencia & López, 2011) and quality of mother-child communication (Laible, 2010). The family climate can be understood as the awareness individuals have of the quality of their relationships within the family, which can be assessed through factors such as family cohesion, conflict and hierarchy in interactions.

In the study developed by Sbicigo and Dell'Aglio (2012) on Brazilian adolescents, high levels of support and cohesion and low levels of conflict in the family were considered as predictors of psychological adaptation. Those who perceived high support and high family cohesion probably felt more accepted and loved by family members, which may have contributed to raising self-esteem and self-efficacy. The authors highlight the fact that individual characteristics can influence the perception of the family climate, resulting in distinct levels of psychological adaptation (Sbicigo & Dell'Aglio, 2012). Variables such as socioeconomic level, schooling and parental conflict may also be associated with problematic behaviours during childhood and adolescence (Borsa & Nunes, 2011). The importance of family participation in the whole process of growth and learning of the child is fundamental. The family relationship and the availability and interest of the parents in the educational orientation of their children are essential aspects when helping the child. Through their different experiences, family can promote children's participation in all activities, both domestic and social, promoting the acquisition of basic requirements for their socialization, training and value system. The participation of the parents in the life of their children is important, in a coexistence like companions, sharing emotions, which contributes significantly to the discipline. The child needs a balance between disciplinary behavior and dialogue, understanding and caring.

5. Facilitating family resilience

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"La résilience, c'est l'art de naviguer dans les torrents."

Boris Cyrulnik, 2001, Le Monde de l'éducation.

What do we mean when we say that someone is resilient?

We mean that someone lived a difficult experience, suffered, overcome difficulties and... surpassed himself!

For example, in the works developed by Yunes, Garcia and Albuquerque (2007) it is concluded that resilience refers to the processes by which individuals deal with everyday problems and how they adapt to solve them. Thus, the same applies to a group, a couple, and therefore a family!

Family resilience is the ability of all its members to focus on solving difficulties (Yunes, Garcia and Albuquerque, 2007) and find positive aspects that promote success and the ability to surpass themselves rather than focusing on the most negative aspects. And what are these positive aspects? It is the ability to find coping strategies, skills and adaptability of families, in order to solve situations that require a change in a moment of crisis.

And how can families do this? In order to do this, families seek key points in each situation that allow them to more effectively solve situations of crisis or stress, at the same time they face these situations as opportunities to evolve and reinforce themselves (Yunes, Garcia, & Aluquerque, 2007). In order to understand resilience, these authors consider not only situations of crisis, but also situations of change, from experiences of tragedy that are more or less serious but that cause change. One of these moments could be, for example, the birth of a child and the respective and different adaptive phases in the pursuit of responsibility and sharing to raise this new element of the family

The authors point out that the different family dynamics allow to identify four types of families: **the vulnerable, the confident, the durable and the regenerative**. Different families have different types of dynamics and, within these differences, race, culture and ethnicity have to be considered, as well as the educational, economic and cultural level, the socio-cultural and economic environment in which they are inserted. Resilient families are able to adopt management strategies to solve major problems, depending on these variables. Thus, we must consider **protection and sharing factors**, which are the promoters of family resilience, and **risk factors**, that is, variables that **hinder the development of resilience**.

Boris Cirulnik stated that resilience is an *oxymoron*, that is, resilience is the capacity acquired from the experience of its inverse. This is the reason why the author calls it a "*wonderful unhappiness*". In other words, without experiencing unhappiness we will not be able to develop resilience skills in relation to it.

Thus, as Oñate & Calvete (2017) point out, family resilience is a process that necessarily implies that the family experiences a period of crisis or chaos, moments of disorganization or prolonged deprivation, and that, having experienced it, becomes capable of reorganizing itself, finding a new equilibrium and thus overcoming adversity. For a better understanding, Oñate & Calvete (2017) present Anaut's reflective definition (2005, p.119), which describes the resilient family process as:

> *" caminho seguido por uma família quando se adapta e evolui no presente e no tempo, respondendo de forma positiva a estas condições, de maneira única, considerando: o contexto, o seu nível de desenvolvimento, o esquema interativo dos fatores de risco e de proteção e – não menos importante – também, o ponto de vista partilhado na família."*
>
> *["the path followed by a family when it adapts and evolves at present and in time, responding in a positive way to these conditions, in a unique way, considering: the context, its level of development, the interactive scheme of the risk and protection factors and - not least - also the shared point of view in the family."]*

Some of the most relevant factors in the process are: emotional growth, family attachment and interactions between protective and risk factors.

With regard to **emotional growth**, this represents the development of maturity. From the point of view of the behaviours and attitudes, it reflects the way in which the individual adapts to the different situations that he faces throughout his life cycle. This process is influenced by several aspects and is related to the parental support received throughout the development process, with consequences for the construction of its autonomy (Mota e Rocha, 2012).

Family ties are related to building interdependent relationships between family members. It is usually initiated between parents and then passed on between parents and children, and can reveal, expressly, the contours of intra-family communication and the way it grows, organizes and develops. This interaction - the family ties – has been changing, and at the same time other types of families appeared - as a human relational core -, in addition to the typical patriarchal family, which was based more on the hierarchy than on the affective ties (Oliveira, & Goulart, 2016).

This affective relational component is essential here, since there is a strong agreement on the part of the authors that family ties promote the healthy and harmonious development of children in and within the family, and that, above all, this development emerges more easily in a family united by strong and secure bonds (Serafim, 2008) than in a dismembered or separated family. Although the legal regulation of parental authority regulates the children care responsibility and, in cohabitating families, the care responsibility is organized through tasks shared by the couple (Oliveira, & Goulart, 2016), the fact is that the existence of ties can make all the difference. In this regard, Passos (2011) argues that it is family ties that build parental relationships, including the capacity to develop feelings of affection among members. In this perspective, Oliveira and Goulart (2016) argue that family ties, began to promote different aspects of family life, from the perspective of happiness to the status of love in the sexual life of couples, so they argue that once there is an equivalent bond between parents and children, it is important to understand them, as promoters of the development of the children, in terms of autonomy and skills for life. Current family assumes the responsibilities - not always in the right way - of caring for, educating and socializing its members, and the fact is that it is within the family that most of the time the individual finds his or her safe harbor (Passos, 2011), and all these phenomena assume importance in projecting resilience among the children of this family. The

supreme right of the child underpin on bases of reflection and decision for their future in harmony. It is important to address what is meant by child resilience. This point is essential in this study.

Resilient children are children who have the ability to overcome obstacles in a healthy way throughout their development. This phenomenon in children is directly linked, for example, to risk factors for contracting a particular disease, which occurs not only in children, but also in adolescents and in the general population throughout the life cycle (Sapienza, & Pedromônico, 2005). Although some theories suggest that resilience is linked to the capacity for invulnerability and invincibility (in some children), other theories argue that resilience concerns the ability they acquire to overcome obstacles (a phenomenon that does not always happen), in other words, it is the child's ability to find resources that allow him to protect himself and defend himself against the risk factors that appear in his daily life (Sapienza, & Pedromônico, 2005). An important and essential aspect in children's resilience is not avoiding conflicts and unpleasant situations but the ability to develop skills to overcome them in different areas such as the social, academic and vocational (Garcia, & Maia, 2004). In other words, the question is not: "*Do not live risky experiences*", the question is precisely to live them, and to overcome them. Resilience is "*a capacidade dos indivíduos para superar os fatores de risco aos quais são expostos, desenvolvendo comportamentos adaptativos e adequados*" ["the ability of individuals to overcome the risk factors to which they are exposed by developing adaptive and appropriate behaviour"] (Garcia, & Maia, 2004).

Parenting, (*CIPE*, version 1.0) means

> *"Ação de tomar conta com as características específicas: Assumir as responsabilidades de ser mãe e/ou pai; comportamentos destinados a facilitar a incorporação de um recém-nascido na unidade familiar; comportamentos para otimizar o crescimento e desenvolvimento das crianças; interiorização das expectativas dos indivíduos, famílias, amigos e sociedade quanto aos comportamentos de papel parental adequados ou inadequados" ["Action of taking care with the specific characteristics: to assume the responsibilities of being a mother and/or father; behaviours aimed to facilitate the incorporation of a newborn into the family unit; behaviours to optimize children's growth and development; internalization of the expectations of individuals, families, friends and society regarding appropriate or inadequate parental role behaviours"] (Concelho Internacional de Enfermeiros, 2005, p. 43).*

According to these authors there are some familiar processes that function as protective factors, namely, the belief system, organizational processes and communication processes.

How do you perceive and study the process of developing resilience? To understand the resilience process, Sapienza and Pedromônico (2005) suggest the analysis of the family history of the children, as well as the experiences that they lived, individually, in order to understand how these histories were able to strengthen them (or not). In this sense, two of the most important points to evaluate are the risk factors that these children run versus the possible resilience factor (Albernaz, 2013) in their life and family context.

According to Winnicott's theory, resilient children have a very strong self, so that when something is not well they can find resources that allow them to get around the situation. Some authors argue that resilient children, instead of giving up, invest energy to change the environment for the better; which in itself represents an enormous potential to face pain and suffering, investing energy to achieve a goal (Garcia, & Maia, 2004). The authors have some agreement that the resilience factor is a good protector in environments with episodes of violence, parental alienation or any other, because it allows these children to overcome the pain that has been caused to them and to improve their quality of life (Albernaz, 2013).

Conclusion

Resilience is a property of the matter that was initially studied in physics to analyse the resilience of materials. Later, the concept was applied and progressively studied in the social sciences to understand the coping and empowerment skills of human beings in contexts of great suffering in the face of life context aggressions. Resilience is now recognized as an extraordinary capacity for development, which is constructed over a lifetime and refers to how to manage adversity, recognizing risk, but simultaneously revealing the ability to act and involve resources, whether personal or family, to face these same adversities (Oñate, & Calvete, 2017). Resilience is considered a variable that promotes health in general and mental health in particular. It also allows us to understand how, when faced with a risk factor, some individuals are able to overcome it in order to get the best out of it (Silva, 2009). Oñate and Calvete (2017) cite this author in the studies he developed to understand how seriously ill people can overcome this adversity, developing the capacity to face, overcome and to emerge stronger and transformed after being confronted with such an unfavorable situation. In short, resilience is more than overcoming a difficult situation (Melillo et al., 2005), it is to get something positive to make the person stronger, more capable, but without their mental and emotional health are affected. The same process applies to the development of family life dynamics. In practical life the idea of resilience applies to someone who reveals himself to be a person who refuses to assume only the status of victim in a circumstance that promotes inner imbalance or chaos, but instead develops capabilities - that he did not have before, or did not know it had - to overcome the obstacles. And in these laborious and complex processes, families can be the protective factors that potentiate the resilience processes of each element, in the singular, and of all in the global, in interaction, in each family nucleus.

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6. Optimal family functioning

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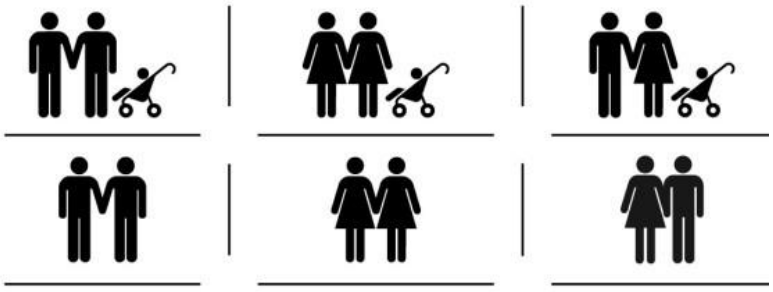
The family represents the core of the development of basic and meaningful interactions, and is considered the first agent of socialization, which legitimates the conception of the first and most important social group. Thus, the family assumes the basic unit of society, where the acquisition of language, the first bodily contacts, and the first interaction between its members and the environment are acquired and promoted. It is from this core that each element, and especially the child, elaborates the sharing of meanings of their experiences, which enables the child to develop as an adult and autonomous human being (Alarcão, 2006; Fazenda, 2005; 2008; Figueiredo & Charepe, 2010).

There are several models of family functioning that, independently of the way they evaluate the dimensions considered by the respective authors, try to characterize the different types of family (Relvas, 1999).

Rodrigues (2012) presents some theories that explain the functioning of the family, the structure, the dynamics and the family change process, and describe the interpersonal structures and the emotional dynamics existing between the elements that make up the family. In this way we can understand the interaction between the events of the environment in which the family is inserted and its individual development, as well as the processes of individualization and differentiation of family elements, in order to be able to present prognoses regarding the health/illness binomial of family, and also to understand the situations of stability and changes that occur in the course of the life cycle.



Thus, the family is a living organism as a whole (system), embedded in larger systems, consisting of smaller totalities (subsystems), in which each element constituting the family system is an integral part of other systems and subsystems, assuming simultaneously different roles in different contexts, which correspond to different statutes and functions and types of interaction (Fazenda, 2005; 2008; Relvas, 1996). Based on this assumption, the experiences of each member of the family system are inseparable from the experiences of other members, and what happens to each element influences the family as a whole.

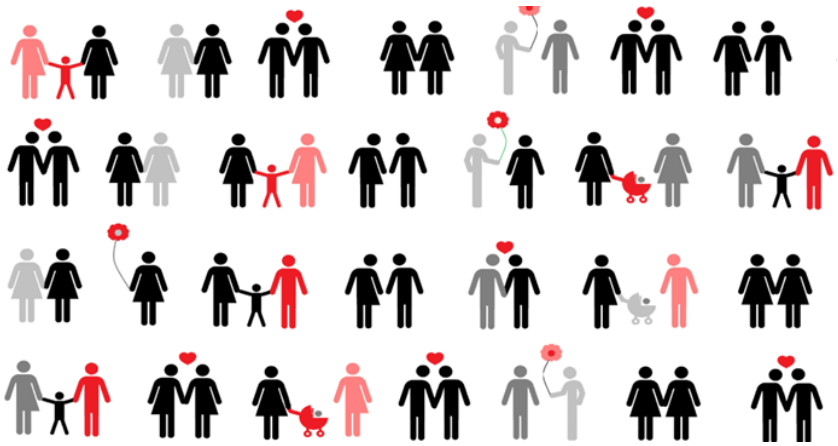
This familiar system presents four subsystems (Rodrigues, 2012) that help to understand its dynamics:

a) **The individual** is represented by the individual who assumes a certain role and family functions, in addition to those he represents in other systems;

b) **The conjugal** is represented by the couple, with the function of developing boundaries and borders protecting the intrusion of other elements. They constitute the basis for the growth of children, representing a relational model for the establishment of future relationships;

c) **The parental** is constituted (usually but not always) by the elements that constitute the conjugal subsystem, but may include a grandfather, a grandmother, for example, assuming functions of education and protection of the children;

d) **The fraternal** is composed of the brothers, and assumes the space-place of socialization par excellence, allowing the experimentation of different roles and development of social-relational skills.



Limits and functional frontiers of the system-family

In classical literature, Minuchin (1979) refers to three types of **boundaries or borders**, which, although they may be different, are identified as: the *clear* (delimiting the space and the functions of each member or subsystem, being possible the communication between them), the *diffuse* (signaled by the great capacity of permeability that threatens the differentiation of the subsystems), and the *rigid* (characterized by the difficulty of communication and understanding between subsystems, and impermeability). Thus, each family nucleus can be classified in a range comprised of an **entangled pole** (diffuse boundaries) and a **dismembered pole** (rigid boundaries).

a. Entangled families are characterized by fragility and permeability, where communication is allowed among the various elements, allowing the autonomy of each individual. In this system, there is strong cohesion, but weak possibilities of differentiation of its members.

b. Dismembered families are excessively rigid, do not promote communication and privilege the autonomy of each of its elements, with feelings of lack of cohesion and belonging, evidencing the differentiation (Alarcão, 2000; Fazenda, 2008).

Rodrigues (2012), explains that although the author defines extreme functionings, there are the following aspects to consider: a) There is no qualitative difference between functional and dysfunctional families: all families are located in a range, delimited by entangled and dismembered poles; b) Any functional family may live in circumstantial periods of greater entanglement or greater dismemberment, depending on the stage of the life cycle in which they live; c) In the same family there may be different types of boundaries between the various subsystems or elements; d) There is a need to situate the family in the cultural context in which it is inserted and in its family history for the evaluation of the degree of entanglement or dismemberment.

Based on the assumption of **intersystems interaction**, the family, as an open system, presents the same properties (Alarcão, 2006):

a) Totality: the functioning of the family is more than the sum of the individual parts of the elements that constitute it. It is important to observe the interaction between them and to analyse the family as a whole, an open and complex system that is formed with more circular than linear interaction patterns.

b) Self-organisation: the capacity of decision-making and autonomy, modifying their structure spontaneously, developing conditions that promote their survival or to remain identical;

c) Equifinality: family interactions and their evolution throughout the life cycle are essential to the process of (self-) organisation towards a goal.

d) Retrospection: in order to understand each of the elements of the family system in the dynamic context, there are actions and feedbacks that link each element to the others. The retrospection can be either positive or negative. Negative retrospection is a mechanism of self-regulation that gives stability through quantitative changes, and positive retrospection is the mechanism of self-regulation, of a qualitative nature, that promotes evolution and creativity;

e) Hologramatic Principle: it defends the possibility of doing family therapy only with an individual who composes the family system, which can help the individual to perceive his role in the whole (system) and the role of the whole system in himself;

F) Homeostasis: the family, as an open system, is vulnerable to internal and external disturbances and therefore reacts to them through homeostatic and regulatory mechanisms in order to restore its functional balance.

Family functioning - Circumplex Model of Family Systems

Family functioning (Lee et al., 2002) represents a complex concept defined by functional dimensions comprising the following constructs:

a) Affective: affective relations between the elements that make part of the familiar system; **b) Structural:** physical, temporal and spatial relations that subsist among family members; **c) Control:** ability of the family system to maintain its autonomy and balance in the integration of rules and values; **d) Cognitive:** competence to solve problems, to identify the needs of the family members and to deal with problematic situations.

Family cohesion, adaptability and communication

The Circumplex Model of Family and Conjugal Systems integrates three dimensions (**cohesion, adaptability and communication**) in the approach and description of the family and conjugal functional dynamics:

1. The family cohesion dimension refers to the emotional connection that exists between the elements of the family system, and is based on variables such as: emotional bonding, affective involvement, marital and family relationships, parent-child relationships, the internal and external limits of the family system, time, space, decision making, friends, interests, and family activities (Olson, 1999, 2000). This dimension allows us to distinguish four types of families:

a) Dismembered families (very low level of cohesion): characterized by great emotional separation and little interaction between the elements, with individual and independent interests;

b) Disconnected families (very low level of cohesion): these families present more emotional interaction than the dismembered ones, but their elements tend to be more independent than dependent;

c) Entangled families (moderate to high level of cohesion): characterized by the sharing of feelings and decisions among its members, but with respect for the freedom of choice and decisions of each one;

d) Very entangled families (High level of cohesion): These families exhibit a dynamic with lack of privacy: decisions are taken together, without individual freedom of choice, and the distinction between their elements is difficult.

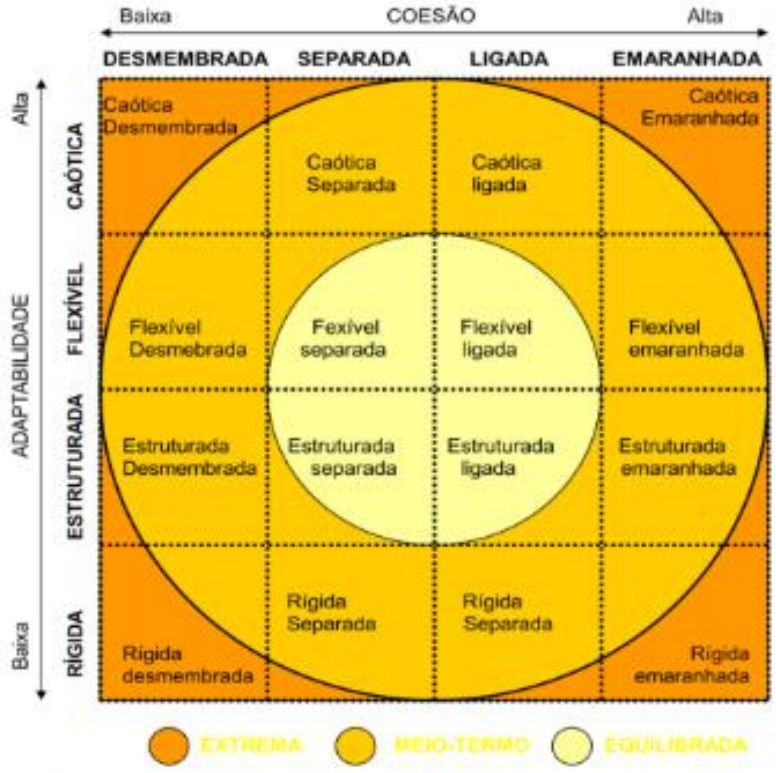


Figura 1. *Modelo Circumplexo (Olson, Bell & Portner, 1992)*

The **high levels of family cohesion** are associated with the little independence manifested between the elements of the family system and the difficulties of individualizing them. In turn, **low levels of cohesion** are associated with high levels of autonomy of the elements that make up the family system and with the low linking to the family system. From the

functional point of view of the family, **the central levels are more adequate**, considering the ability to be simultaneously independent and remain connected to the family (Olson, 1999; 2000).

In this model it is considered that the higher levels of cohesion, as well as the lower levels, show a greater predisposition to individual problems or to long-term relationships. On the other hand, relationships in which the levels of cohesion are moderate are more likely to establish the balance between being alone and being together. However, there is no ideal level, because if a relationship is sustained by one extreme for a long time, there will certainly be problems (Olson, 1999; 2000).

2. The family adaptability dimension - capacity to change the power structure, the relational roles and the rules of functioning in situations that generate situational or developmental stress. This dimension includes the type of leadership, discipline, types of negotiation, roles and rules (Olson, 1999; 2000). In family adaptability it is also possible to identify four types of families:

a) Rigid families (very low levels of adaptability): characterized by authoritarianism, control, very limited negotiations, with unclear rules (which have to be fulfilled) and rigid discipline. In this type of families emerge changes or alterations;

b) Structured Families (low to moderate levels of adaptability): have little shared leadership, have democratic discipline and demonstrate the ability to change;

c) Flexible Families (high to moderate levels of adaptability): these families reveal shared leadership, democratic discipline, and change skills when necessary;

d) Chaotic Families (very high levels of adaptability): They organize themselves with little discipline, unclear rules (which often vary), lack of leadership and thoughtless decisions.

With respect to **adaptability**, we can say that there is an association between the lower levels and the capacity of resistance to the change of the familiar system, existing little adaptability in the circumstances. On the other hand, the higher levels are characterized by a great adaptability, which promotes the growth and development of the system. At moderate levels, family system changes only when needed (Olson, 1999).

3. The communication (third dimension) is the variable that facilitates the movement between cohesion and adaptability, and is measured by communication skills (active listening, empathy, clarity, mutual sharing of feelings). Balanced families promote excellent communication, and imbalanced families promote poor communication.

The combination of the four levels of each dimension, cohesion and adaptability, allow to distinguish sixteen types of families, according to a two-dimensional matrix. Each of the family types was later regrouped into three types (Olson, 1985):

- Balanced families: they have balanced levels in the two dimensions and, therefore, correspond to flexible disconnected, flexible entangled, structured disconnected and structured entangled types;

- The average families: they have two balanced levels in one of the dimensions but have extreme levels in the other: they correspond to the types very flexible disconnected, very flexible entangled, flexible dismembered, flexible very entangled, structured dismembered, very entangled structured, rigid disconnected, rigid entangled;

- Extreme families: with extreme levels in the 2 dimensions: they correspond to the types dismembered very flexible, very flexible very tangled, dismembered rigid and very tangled rigid.

The Circumplex Model and family functioning

a) Balanced Families reveal more adequate functioning than Imbalanced Families. Balanced families function more adequately (cohesion and adaptability) than those that are situated at the extremes of any of these dimensions. However, extreme behaviours, in both dimensions, may be appropriate at certain stages of the life cycle or in stressful situations, but can be problematic if families remain at these extremes (Olson & Gorall, 2003).

b) If family expectations are based on more extreme standards, families will function more adequately as long as all elements work in the same way. If the family expectations allow manifestations of extreme behaviour in any of the dimensions, the operation will be all the better the more satisfied all elements are with those expectations.

c) Balanced families have more resources and a greater predisposition to develop more positive communication skills than extreme families, where positive communication skills allow the family system to maintain a balance between cohesion and adaptability. On the other hand, deficit communication skills prevent movement in unbalanced systems and increase the likelihood of these systems to remain at extreme levels (Olson & Gorall, 2003).

d) Family systems change in response to stressful situations and developmental needs: balanced families have more resources and skills to change their system, taking over and managing the crisis as an opportunity for growth. Unbalanced families do not have the necessary resources to change, so they can experience more difficulties in adapting to crises.

Family Functioning in a Critical Context - A Child With SN (CSN)

The family is exposed to internal and external pressures, and there are sources of stress (Minuchin, 1979) which identify specific critical contexts:

a) Contact of an element of the family with a source of extra-familiar stress which the other elements feel, and the need to trigger changes in order to better manage the problem(s) developed;

b) Contact of all elements of the family system with an extra-familial source of stress: a family facing a stressful situation to be able to demonstrate or not mutual support skills, necessarily implying changes in their functioning patterns;

c) Stress associated with the transition periods of the family life cycle: a phenomenon associated with transitions from one process to another in the family life cycle, and thus expected and normative.

d) Stress promoted by particular problems: unlike the category previously described, it is unexpected and not normative. It can significantly affect the structural organization of a family system (e.g., chronic or prolonged illness, an element with new and great life support requirements), which is why the family has to reorganize its transactional patterns in order to respond functionally to the stress caused by these situations.

The family system in the course of its life cycle may experience natural crises and accidental crises. Natural crises relate to the different stages of the life cycle and are expected and

predictable. Accidental crises are associated with those described above, and they happen in an unexpected way, which is why they are normally perceived in a dramatic way (Alarcão, 2006).

Impact of a Child with Special Needs (CSN) on the Family

The family builds its course through transitions that, faced with the emergence of new contexts, require the change of familiar patterns and functional responses, in order to maintain the effective functioning of the system. In this sense, having a child with special needs (CSN) or with special educational needs (CSEN) assumes a non-normative transition, which brings together the recursion between the family life cycle and the elements that constitute it, which involves intrinsic co-evolution by the complexity of the required dynamic adaptation. As a chronic stress variable, it is manifested by changes in three levels:

a) Structural level: changes characterized by emotional coalitions and exclusions that result from rigid patterns that make it impossible to negotiate and redefine roles;

b) Procedural level: changes induced by the difficulty in mobilizing effective coping strategies in the face of the interdependence between the individual cycle, the family cycle and the cycle of the disturbing phenomenon;

c) Cognitive-emotional level: changes in communicational requirements and which indicate the possibility of emerging changes in the communication pattern making it dysfunctional, such as the high expression of emotions or silences.

Thus, the presence and coexistence with a CSN or CSEN corresponds to a moment of crisis, insofar as it triggers changes in the life of the individual and his family at the level of the structural, developmental and functional dimensions, involving the redefinition of roles, extending to interactions with other systems (Figueiredo, 2009). These contexts bring to the surface the meanings related to the context and that allow the control (or not) and the perception of the competence (or not) of the family, with a continuity often associated with experiences of guilt, self-incrimination and victimization (Rolland, 2000).

This is why **cohesion, adaptability and communication** are fundamental elements for the understanding of family functioning, since they bring together the necessary changes in the interaction and context experienced by family members in a crisis situation.

The family coexistence with a Child with Special Needs (CSN) or with Special Educational Needs (CSEN) comprises a set of experiences described as family burden, so the CSN or CSEN impact on the family affects a wide range of the dimensions of family life. In addition, it is important to recognize the potential of family resilience in the face of the unexpected and unwanted condition of having a relative - CSN or CSEN - that represents a challenge in managing the balance between vulnerability factors and stressors (Fazenda, 2008).

Family burden

The concept of family burden can be defined by the set of problems, difficulties or events that have a significant impact on family life and correspond to the element of suffering (Platt, 1985), which can be clearly associated with the presence of a CSN. The burden may be **objective and/or subjective** in nature, as it relates to material consequences (concrete and observable negative consequences resulting from the presence of a CSN or CSEN in the family), such as financial losses, disturbances in the social and professional life of family members, additional tasks that the family has to perform to take care of all aspects of the child's life,

disturbances in the relationships between the elements that make up the family system, emergence of problematic behaviours that family members need to know how to manage, avoiding them or acting according to its consequences. The **subjective burden** concerns the emotional impact: the personal perception or evaluation of the family on the situation, understanding the emotional relationships and the feelings of being suffering that are developed resources to face them (Alarcão, 2006). Many families living with a CSN show a resilience potential that allows them to respond to the adversities of this same condition, an overload due to the confrontation and the context of creating a CSN, since all areas of family functioning may be influenced by the presence of a CSN or CSEN.

Family resilience

Resilience is about the ability of individuals and families to meet the challenges they face, intertwining with the concept of vulnerability and regenerative power that involves the system's ability to minimize the disruptive impact of a crisis situation. This process occurs through attempts to influence the demands, while resilience represents the characteristics and properties of the family system that gives it resistance to change and adapt in crisis situations (McCubbin & McCubbin, 1989).

According to Marsh (1996) the concept of resilience is associated with **familial, social and personal factors**. Familial factors correspond to the **early affective bonds of family members, to the quality of family bonds, to the style of parental relationships and to the type of emotion expressed in the family. Social factors refer to the educational experience of the elements that make up the family, the sociocultural level of the family, the quality of support and the family social network. Personal factors**, on the other hand, relate to the social competences of the elements that make up the family, the personality, the representations of oneself and the other elements that constitute the family system.

Taking these elements into account, it is important to mention that the family system has the capacity to withstand adversity, courage to face difficulties, tolerance for different behaviours and adaptive skills in complex situations. There are also skills that can be acquired (Davydov, Stewart, Karen & Chaudieu, 2010), such as how to better deal with crises, to identify signs of decompensation, and how to maintain needs among the elements that make up the family system (Fazenda, 2008). It is through resilience that the system adjusts and adapts to the CSN or CSEN (Walsh, 2005).

For all these variables, family resilience reduces the effects of family burden, since the family has strong resources and knowledge that can be used, such as coping strategies and management of stressors.

The family functioning with CSN or CSEN - a differentiating context

The presence of a CSN will reflect in some way on the functioning of the family system, and in particular on the level of maintaining the homeostatic balance of the family system. In his studies on mental disturbance in family contexts, Ausloos (1996) advocates 3 levels of understanding of the symptom: semantic (what the symptom indicates), syntactic (indicates to whom and according to which rules) and pragmatic (for what purpose). In this sense, the child becomes understood as a child/patient/disabled, identified as an element of the family system

suffering from malaise, suffering or family dysfunction, so that individual psychopathological diagnosis ceases to make sense, favouring the relational assessment (Alarcão, 2006). Thus, this author sees the family as the relational space of excellence, electing it in this way as the context of reading the meaning of the symptom, as well as context of change.

The systemic perspective did not develop family nosography, adopting the designation of family dysfunction, identifying three parameters of analysis: the structural hierarchy, communication and the stage of the life cycle, variables from which two major types of families are obtained:

- The functional (characterized by positive feedbacks aimed at change) and,
- The dysfunctional (the change is not perceived as an opportunity for growth, but as a threat, so the system reacts with negative feedbacks, focusing attention on the dysfunctionality of the CSN, in order to avoid change and to keep its functioning) (Alarcão, 2006).

Due to the self-corrective logic, in which the dysfunctionality is explained by the dynamism of the system, it is important to understand the relation between the appearance of the symptom and the type of family functioning, that is, to try to understand that certain families, in proportion to their functioning, make possible the emergence and maintenance of the symptom (Alarcão, 2006, Relvas, 1999).

We conceptualize the CSN or CSEN as a moment of crisis, insofar as it promotes changes in the life of the individual and his family at the level of structural, developmental and functional dimensions, which implies the redefinition of roles. The coexistence with a CSN or CSEN comprises a whole set of described experiences, and would therefore be considered the burden as a product of the CSN or CSEN impact on the family. On the other hand, it is important to recognize the family resilience potential, which allows them to respond to adversities of this same condition (Fazenda, 2008). In this sense, it is important to realize the role that family dynamics can play in the emergence of mental illness, reporting to the symptomatic families. Therefore, the symptom appears as a message that reflects the functioning of the family system in which the individual is inserted, considering the function of maintaining the homeostatic balance of the family system (Alarcão, 2006).

Considering the self-corrective logic, in which dysfunctionality is explained by the dynamism of the system, it is important to understand the relation between the appearance of the symptom and the type of functioning of the family, that is, to try to understand that certain families, depending on their functioning, enable the maintenance of the symptom (Alarcão, 2006).

The life cycle of the family is marked by moments of stress, tranquillity and satisfaction, so we can infer that relationships are sustained, the elements are growing and the family system is developing. Behaviours evidenced by family relationships may emerge randomly or as a function of internal or external determinants: behaviour in a critical context can produce results that would not occur if the family system were not in a situation of imbalance. For example a behaviour of an element of the familiar system will be selected and privileged by the remaining members of the family system, and may or may not be replicated by the meaning attributed by itself or by other elements. In this sense and considering the difference between behaviour and conduct, the prevalence or not of attitudes and behaviours in the intrafamily system, specifically marks the contours of its life cycle and somehow identifies the type of family.

TYPES OF FAMILY - Type and Characteristics

In order to present a clarifying approach to the functional dynamics of the systemic structure that the family is, the schematic organization of the *Novos Tipos de Família* (New Types of Family), elaborated by Caniço, Bairrada, Rodríguez & Carvalho (2010), is adopted, which briefly explain their multiple functional interactions.

1. From the point of view of the Structure and global dynamics

- *Família Díade Nuclear* (Nuclear Dyad Family) - Two persons in a marital relationship without children (there are no common descendants or previous relationships of each element).

- *Família Grávida* (Pregnant Family) - Family in which a woman is pregnant, regardless of the remaining structure.

- *Família Nuclear ou Simples* (Nuclear or Simple Family) - A single union between adults and a single level of descent - parents and their child(ren).

- *Família Alargada ou Extensa* (Extended family) - They co-inhabit ascendants, descendants and/or collaterals by consanguinity or not, in addition to parent(s) and/or child(ren).

- *Família com prole extensa ou numerosa* (extended or large descent Family) - Family with children and young people of very different ages, regardless of the remaining family structure.

- *Família Reconstruída, Combinada ou Recombinada* (Reconstructed, Combined or Recombined Family) - A family in which there is a new conjugal union, with or without descendants of previous relationships, of one or both spouses.

- *Família Homossexual* (Homosexual Family) - A family in which there is a conjugal union between two persons of the same sex, regardless of the remaining structure.

- *Família Monoparental* (Single Parent Family) - Family consisting of a parent who cohabits with their descendant(s).

- *Família Dança a Dois* (Two Persons Dancing family) - Family consisting of relatives (blood or not) without marital or parental relationship (e.g., grandmother and grandson, aunt and niece, siblings, cousins, brothers in law,...).

- *Família Unitária* (Unitary Family) - Family consisting of a person who lives alone, regardless of marital relationship without cohabitation.

- *Família de Co-habitação* (Co-habitation Family) - Men and/or Women living in the same house without family or conjugal bonds, with or without common purpose (e.g., university students, friends, immigrants,...).

- *Família Comunitária* (Community Family) - Family composed of men and/or women and their descendants, cohabiting in the same house or in nearby houses (e.g., religious communities, sects, communes, gypsies, etc.).

- *Família Hospedeira* (Host Family) - Family in which temporary placement of an element outside the family occurs (e.g., child, elderly, friend, colleague,...).

- *Família Adoptiva* (Adoptive Family) - A family that has adopted one or more non-consanguineous children, with or without the cohabitation of biological children.

- *Família Consanguínea* (Consanguineous Family) - A family in which there is a marital consanguineous relationship, regardless of the remaining structure.

- *Família com Dependente* (Family with a dependent) - Family in which one of the elements is dependent on the care of others due to illness (bedridden, mentally and/or motor disabled, requiring support in Daily Life Activities.

- *Família com Fantasma* (Family with a Phantom) - Family experiencing the permanent disappearance of one of its elements definitively (death) or is experiencing a situation that is difficult to reverse (divorce, kidnapping, disappearance, unknown motive) in which the missing element is still present in the family dynamics making it difficult to reorganize the individual development of the remaining members.

- *Família Acordeão* (Accordion Family) - Family in which one of the spouses is absent for prolonged or frequent periods (e.g., expatriate humanitarian workers, military personnel on mission, long-term emigrants).

- *Família Flutuante* (Floating Family) - A family in which the elements often change housing (e.g., parents with variable location employment) or where the parent often changes partners.

- *Família Descontrolada* (Uncontrolled Family) - Family in which a member has chronic behavioural problems due to illness or addition (e.g., schizophrenia, drug addiction, alcoholism, etc.)

- *Família Múltipla* (Multiple Family) - Family in which the identified element integrates two or more families, constituting different family units, possibly with descendants in both.

2. From the point of view of the Conjugal Relationship that integrates it:

- *Família Tradicional* (Traditional Family) - Family structured according to the feminine/masculine gender, differentiated, in which each member has a pre-established role in the family and in the community.

- *Família Moderna* (Modern Family) - A family in which gender equality is the basis of unity, regardless of its type. There is inter-help and solidarity with the structural and power balance between men and women.

- *Família Fortaleza* (Fortress Family) - Family in which the internal dynamics have pre-established rules difficult to modify, with closure to the outside, difficulty in taking on problems or adapting to new situations.

- *Família Companheirismo* (Fellowship Family) - Family in which there is sharing and distribution of activities, common objectives, evolves with external experiences and contacts.

- *Família Paralela* (Parallel Family) - A family in which the spouses do not share daily activities or life goals, existing an attitude of closure abroad and difficulty in achieving openness to change living habits.

- *Família Associação* (Association Family) - Family in which there is affective union, although no daily activities are shared. It is based on individual freedom and is a show of selfishness in certain circumstances.

3. From the point of view of the functional dynamics of the Parental Relationship

- *Família Equilibrada* (Balanced family) (stable) – it shows itself united and parents are consistent and aware of their role.

- *Família Rígida* (Rigid Family) (unstable) - there is difficulty in understanding, to take on and follow the healthy development of children.

- *Família Super-protectora* (Super-protective family) (unstable) - there is excessive concern about protecting children, parents being super-controllers.

- *Família Permissiva* (Permissive Family) (unstable) - Family in which parents are unable to discipline their children.

- *Família Centrada nos filhos* (Children-centered Family) (unstable) - parents do not know how to face their own conjugal conflicts, which devalue without evaluation and adjustment.

- *Família Centrada nos pais* (Parent-centered Family) (unstable) - parents' priorities focus on individual personal projects (professional or playful).

- *Família Sem objetivos* (Family Without Goals) (unstable) - parents are confused by lack of common goals and targets.

Impact of Family Variables: Structure and Functioning

Fonseca and Simões (2002) found that the most relevant family variables in the study of antisocial behaviour fall into two categories: structural and functional variables. Structural aspects generally refer to the socio-economic level, the level of education of the parents, the number of siblings, the existence or not of completeness in the families, or the area and the conditions of residence.

The impact of structural variables is felt indirectly through their impact on the family **functioning** (Fonseca & Simões, 2002). This impact is verified in the conflicts in the couple, in the neglect or abandonment of the children by the parents, and the existence in the family of people who with their attitudes and behaviours propitiate the learning of deviant behaviours. This phenomenon emerges from parents' lack of educational skills (inability to supervise and discipline, lack of capacity for mutual respect and inability to protect her against possible risks of antisocial behaviour). Parents with low self-control tend to pass this characteristic on to their children, who become apparent when young people bond with peers or seek out situations that fit their own characteristics. Antisocial behaviour does not seem to emerge from deviant learning (e.g., imitation of delinquent behaviour patterns in the family or group pressure), but rather as a consequence of deficits in the process of socializing the child within the family itself, and in particular from the lack of parental control and supervision (Fonseca & Simões, 2002) and parents' failure to acknowledge and punish the child's deviant behaviour when it occurs (Gottfredson & Hirschi, 1990; Hay, 2001).

Family variables in self-control

Children tend to behave in an antisocial, self-centred, or impulsive manner, so they need the family to teach them not only to self-control themselves and to resist the temptations of the moment, but to supervise them by drawing attention to their impulsive behaviour, punishing their transgressions and indicating the correct behaviour (Fonseca & Simões, 2002). Through this parental educational action, the child will know how to plan or think about the consequences of their actions and contain the tendency to immediately satisfy their own impulses or desires, most often at the expense of others (Fonseca & Simões, 2002). According to Hay (2001), this parental educational action should occur before entering school, because it is during this phase that self-control is established and will be maintained throughout life. The role of parents and families in developing children's capacity for self-control may be the first vehicle through which they can influence adolescent behaviour problems (Feldman & Weinberger, 1994). Thus, the

major task for parents and the family is to regulate children's behaviour in order to gradually promote self-regulation and reduce the need for external control. If this task is successful, these family practices will become partially internalized by the child and become personality traits. According to the social and cognitive theories of Bandura (1986), and psychoanalysis (Feldman & Weinberger, 1994), self-control is developed first in specific and meaningful relationships through processes such as identification and modelling. Parental behaviour in assertive power, inconsistency, and self-centring may interfere with the proper development of children's self-control, because of what they give as an example.

About Family Functioning - Research Answers

Functional Family Assessment

Although there are methods of assessing the family relationship, there is no consensus about which measure would be the most appropriate and what would be the focus of the family assessment - whether the marital relationship or the interaction between parents and children. Bray further states that these issues must be defined according to the purpose of the assessment. In the present study, there was a predominance of assessment of the interaction between parents and children.

According to Bray, theories about family and marital functioning suggest four categories that should be assessed: **family composition** - description of family structure and members; the **family process** - includes behaviours and interactions that characterize family relationships, such as conflict, differentiation, communication, problem solving, and control; the **affective factors** - emotions and affective expression among members - and **family organization** - refers to roles and rules, including aspects such as boundaries and hierarchy.

Bray found some important key factors and processes: communication, emotions, roles, marital and parental conflict, problem solving, bonding and cohesion, expression of affection, intimacy, stress, differentiation, and individuation.

Family functioning is associated with the need to understand the characteristics of families when their functioning is healthy, unbalanced or dysfunctional (Lopes, 2014). The family develops in a dynamic process of evolution and change throughout the life cycle.

A study by Shek, Xie and Lin (2015) aimed at investigating functioning differences between intact families and other family types:

- Intact nuclear families perceive themselves as having better communication and less conflict than other families; they have a better level of parental control than families of other types, and their adolescent elements have a higher psychological control than adolescents from intact non-nuclear families; and adolescents from intact nuclear families are more satisfied with parental control than adolescents from families who are not nuclear intact.

In the study by Cerveira (2015), no statistically significant differences were found in the different family configurations at the level of perceived family functioning, but the adolescents perceive the family functioning in a more negative way than the parents.

Other points of interest in these functional contexts are expressed by:

- Intact nuclear families exhibit more satisfactory levels of cohesion and adaptability than other family configurations (single-parent, reconstituted, and extended).

- Different family configurations present different levels of self-concept, and adolescents from intact nuclear families present a higher self-concept perception.

- The perception of the self-concept of the adolescent is related to the perception of the familiar functioning: the more functional the family is perceived, the better is the self-concept of the adolescent son.

- Female single-parent families perceive their family satisfaction in a more negative way than expected (Grzybowski, 2003, cited by Cerveira, 2015) in areas of satisfaction such as economic/professional, psychological, affective-sexual, parental and social support.

- Single-parent families (Cerveira, 2015) are not satisfied with regard to the various types of relationships (professional, affective, family, or friendship) and have shown a strong tendency towards entanglement in the mother-child dyad.

- Cerveira (2015) presents the conclusions of Wall and Lobo (1999) regarding single-parent families in Portugal: 1) the single-parent family results more and more rarely from widowhood, children outside marriage or parents abroad: divorces or separations are the most common cause of single parenting; 2) there are currently 3 distinct single parenthood situations, parents/mothers of a certain age living with adult children; single mothers/fathers, living with minor children; and separated or divorced mothers/fathers living with children under the age of 25; 3) the profile of single-parent Portuguese families is similar to the profile of other Southern European countries: there is a very low proportion of parents living with minor children compared to parents living with adult children and the existence of a proportion of single-parent families to live with other persons and/or family groups.

- Female single-parent families report a good perception about their family strengths, social support and their mental health (Lucas, 2012). Mothers with fewer children and those who perceive psychological well-being have a better perception of family forces compared to mothers who have more children and with apparent psychological distress.

- The reconstituted families originate in a marriage (Marangoni and Júnior, 2011) in which at least one of the spouses was already married and had another family of which they are children.

- In reconstructed families (Kennett, 2001), parental roles and behaviours follow conventional expectation/stereotypes. However, older stepchildren tend to view themselves in a more negative way as to how they function, just like stepparents in their parental roles with older children.

- Family functioning in reconstituted families is influenced by the functioning of the couple and by the gender of the older stepchild: functioning is best when the oldest stepchild is female, and when there is agreement among the family members regarding parental values.

- Extended families (Minuchin and Fishman, 1981; cited by Vicente & Sousa, 2010) have a determining influence on nuclear family functions, since they preserve emotional ties that are related to the past.

- The study carried out by Vicente e Sousa (2010) in 25 multigenerational families shows that the older generations perform fundamental family functions, giving them a more prominent position in the extended family system.

- The various types of family today reveal new family dynamics, reflecting an evolution that may cause serious social problems on the one hand, but on the other, they present new congruent ways of living, hitherto unknown, but possibly approved over the time (Rúa, 2005).

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Part II.

Parents' guide to promote social-emotional learning for children with special needs

1. Effective parenting

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Chapter summary

In this chapter is presented a selection of relevant and applicable information regarding the actual parenting. The main mechanisms by which the family context and parents' actual behaviours influence children's emotional behaviour are approached. At this level the child's learning to adjust its emotions is seen thorugh the emotions development theory (Tomkins, 1991), the two parental styles model (Zeman et al., 2010) and the tripartite model of the family influence (Morris et al., 2007). The parental styles and their influence in the child's emotional development are approached from two different perspectives but equally applicable: the attachment perspective (J. Bowlby, 1951, 1969, M. Ainsworth, 1967, 1973) and the perspective of the emotions socialization parenting style (Zeman, 2010, Houltberg, Henry & Morris, 2012, Malatesta – Magai, 1991). In the third sequence it is offered the possibility to self-assess the parenting style by a scientifically validated instrument. An adequate parent-child emotional interaction substantiates the formation of the child's emotional and social skills. In this regard, the last sequence of this chapter offers the possibility of being aware of the parental strategies you use more frequently and modify them in order to obtain a more efficient parenting.

1. Glossary/Words to know/Definitions

parenting, parenting styles, emotion regulation, intergenerational emotion regulation, emotional coaching, attachment styles, emotional socialization, emotional coping, gender influences on parenting, parental strategies

2. Theoretical background and discussion

a. Responsive and proactive parenting

The most important social context in which the relevant emotional experiences are built is family. Parents' answers to the child's emotions, family's emotional climate and the interpersonal relations are the main factors identified by the theory and research regarding socialization in family context (Fosco, 2012). In Eisenberg's vision, the emotional development in the family context is the consequence of the parent's reactions/responses to the child emotion but also of the parental expressivity and the child-parent discussions about emotions.

The emotions are transmitted between generations

From the *Emotions Development Theory* (Tomkins), the responsive and proactive parenting involves the idea of transmission between generations of the socio-emotional moods. The repeated emotions are in time incorporated in the personality structure as "ideo-affective organizations" or emotional biases. Once defined, they act as filters or amplifiers of the affective information. Parents' attitudes and beliefs become manifests in the socialization process and are previously transposed in the tolerance or intolerance to the child's emotions. In Tomkins' opinion, parents' ideo-affective position is reflected in two emotional socialization practices: reward and punishment. A punitive socialization leads to a style which sorts the negative emotions because they, according to the learnt expectances, are undesirable in an inter-personal context (Magai, 2004). Thus, the parent has the responsibility of becoming conscious, active and proactive in its own personal development process.

Acceptance or emotional rejection?

Gottman, in *The model of the two parenting styles* (Zeman et al., 2010), speaks about an attitude of the parents in their relationship with the children of an *emotional coaching* type or *emotions rejection*.

• The parents that develop a coaching type relationship consider the children's negative emotional experiences as being healthy and suitable for learning, adjust their own emotional reactions to the children's affective experiences, establish clear behavioural boundaries for the emotional behaviour, they communicate empathically, try to understand the children's feelings, help them verbalize these feelings, involve with the children in finding the most constructive way to manage the emotional situations.

• Instead, the parents that reject the emotion see the negative effects as awful and try to protect their children of the negative emotions experience, have a poor emotional vocabulary, do not identify their children's and their own low intensity emotions (Zeman et. al., 2010).

The family context is in itself a modelling factor in the parent-child relationship. From the *Family Influence Tripartite Model* perspective (Morris et al., 2007) parenting acts through: observation/ modelling, parenting practices and family emotional climate. The last one is defined by the parent – child attachment relationship, parenting style, family's emotional expressivity and the marital relationships emotional quality.

Thus, a parent that is healthy connected to his own emotional structure will find the correct sense of its child emotional structure and will transform them into resources for the child's growth and development in an integrated manner: emotional, social, cognitive. Responsive and proactive parenting means involvement, modelling, adjustment first at a personal level and then in the inter-familial relationships.

b. Parenting styles

b.1. Attachment relationship as parental style

> *At the age of 13 months, Keshia liked to go to picnics with her parents. There were always coming other families and there were lots of interesting stuff to do or see. One day, the parents were sitting at a table in the garden, talking to other parents. Keshia was a few meters away, in a group of children*

of different ages. As she has just learnt to walk, she was frilled that she could walk on her own to join a group of bigger children. She was eager to play the catch with them. Although she did not understand the rules, she played enthusiastically with them for a few minutes. However, she suddenly became confused, not knowing in which of the adults groups around her the parents were. She stopped in the middle of the road and started looking around, ready to burst into tears. Exactly when she burst into tears, heard one of the other parents saying: look there are mommy and daddy. Sobbing, Keshia ran to her parents. Mother lift her up and put her on her knees. Almost immediately, Keshia was ok. After just one minute she was happy and smiling, ready to get down and start exploring again.

Identify possible causes of the behaviour described below:

(Harwood, Miller, Vasta, 2010)

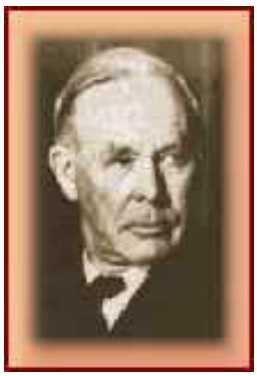
Which do you think the emotions are beyond the expressed tensions?

Which of the persons feels more vulnerability?

Ce este ataşamentul?

What is attachment?

Attachment is one of the basic needs of the human being, manifesting itself since birth and aiming at survival.



As a result of the studies done on animal and mentally disturbed children behaviour, the psychologist J. Bowlby (1951, 1969), considered attachment as being "a class of social behaviours with a specific function, aiming at maintaining proximity with another human being considered stronger and able to protect".

Based on the studies. J. Bowlby identified a few principles of the attachment:

a) the child is born with the predisposition of becoming attached to the person who takes care of him, this one being privileged then the other adults;

b) the child will organize its own behaviour aiming at maintaining this attachment relationship, essential for its physical and psychological survival;

c) the child tends to maintain these proximity relationships in case of danger, even with the price of disturbing his well adjustment to reality.

The studies done by Bowlby were taken over and further developed by Marilyn Ainsworth, so that the attachment could be understood and defined in the area of the normal human behaviour

and extended beyond childhood specific relationships. From this point of view, the attachment is considered as being the profound and long lasting emotional link which connects two persons in time and space (Ainsworth, 1967, 1973).

When and how attachment is formed?

Babies have a natural inclination of becoming attached, but they have to receive constantly from their parents the attention and affection they need to fulfil their needs.

Erikson (1950) thinks that the babies go through the stage in which they solve their first psychosocial crises in the first year of life –"trust versus mistrust". Life experiences build (or not) the faith that the important people for the child answer or not to his needs of adjustment to reality. During the first year of life the basis of the first value – hope are set, felt like the belief that the needs can be satisfied and they can get what they want. In this context, extern predictability becomes internal certainty (Erikson, 1950).

Thus, early experiences with the mother/care giver are important in the attachment relationships development. The quality of the relationship will depend on the adult's ability to get closer to the child, answer its needs, giving at the same time behaviour models which, in its turn, the child will manifest in the future.

What attachment styles are formed?

These three attachment styles were identified by Marilyn Ainsworth in 1967 in an experimental situation. The Canadian author noticed 76 toddlers (12-18 months old) and the way in which their mothers answered their needs (feeding, crying, comforting, visual contact and smile). Adding the way the child reacts to the separation from its mother, the author identified three distinct attachment patterns: securing attachment, avoidant attachment and ambivalent.

Getting back to the example analysed at the beginning of the chapter, Keisha's behaviour is an example of attachment which can be defined as a long lasting emotional relation between the child and the significant persons in her life. The attachment relationship builds the feeling of trust and safety, essential for the exploratory behaviour, for emotions expressing and adjusting, for learning the cognitive and behavioural repertoire and for the ulterior detachment of the child from its family (Jaffe, 2010; Cole & Deater-Deckard, 2009).

1. The securing attachment type

Keisha's reaction in finding her parents signifies a *securing attachment type.* A child with a securing attachment type leaves to explore the areas, objects or persons whom he does not know, taking its mother as security basis. The importance of a securing attachment is essential in the early development because the persons taking care of the child are the primary source for emotions adjusting (Izard et. al., 2011). Secure attachment at 18 months predicts the way in which emotions are adjusted at the age of three years old. Researches on teenagers who answered at the adults attachment interview (AAI- Main & Goldwyn, 1984) indicated that teenagers with a high level of RE qualified their attachment relationship with the parents as secure (Morris et al., 2007).

2. The Avoidant Attachment Type

If Keisha weren't upset at being separated by her attachment figure, but when meeting her mother she would have looked elsewhere and avoided eye contact we would have identified *an avoidant attachment type*. A child that is reserved towards the social environment, who assesses more than it involves, has internalized a relationship of avoidant attachment. This type of attachment increases anxiety, decreases involvement in social relationships availability and thus a vicious isolation circle is created (John, & Gross, 2004).

3. Resistant or ambivalent attachment type

If Keisha had been extremely upset when she realized she was not next to her parents and would have continued crying and manifesting fury when mother took her in her arms we would have spoken about *an ambivalent or resistant attachment type*.

Considerations regarding attachment manifestation in adult age

The persons with a safe attachment are not afraid to depend on the others or others to depend on them. They think that they are worthy of love and respect and trust people. They are very warm persons, succeeding in getting close rapidly to other people and create intimate relationships, without the fear of being abandoned or suffocated. They are not afraid of loneliness.

The persons with an avoidant attachment style appreciate loneliness, isolation, do not trust the others and do not want to depend on them. They are afraid of the stable relationships. These are very distant in a relationship, although their partners desire to get closer to them.

The persons with ambivalent attachment are very hesitating and demand from their partner lots of affection proofs and closeness because they think that this one does not love them or wants to abandon them. They have the conviction that they are not loved and appreciated as they should be. These persons have a low self-esteem and the tendency to reveal too much about them. They are very jealous and possessive. Usually, they are perceived by the others as being to persistent and suffocating.

Considerations regarding parenting

The attachment relationships have an increased degree of resistance in time, succeeding in marking the intimate relationships too and the relationships with their children because during childhood people develop the so-called *internalized functioning model* of the close relationships.

Certain parental factors are decisive for the attachment safety development. Of great importance are the parents's emotional sensitivity and receptivity (De Wolff & van Ijzendoorn, 1997).

Numerous studies proved that the uncertain attachment towards the mother constitutes a risk in the children's socio-emotional development in the future (Buyse et al., 2011). In this sense, it becomes natural that the uncertain attachment (especially when combined to other development risk factors, as the chaotic environment at home and the unconscious or hostile mother's or others members of the family behaviour) is associated with an increased risk degree for both behaviour problems internalization and externalization.

Otherwise, the attachment patterns are transmitted between generations. Mothers with a safe attachment or who understand their own uncertain attachment are more sensitive at the

baby's attachment signals, helping them to form a safe attachment towards them. The mothers preoccupied by the inappropriate attachment relationships in the past are intrusive towards the child's behaviour and are perceived by the children as being irritated. The ones that reject the attachment memories from the past are cold and unreactive to their children attachment behaviours.

Attachment modification The researches done on children with anxious or avoidant attachment proved that those were less aggressive if the parenting improved.

The children with a safe attachment were relatively immune to the parenting's negative changes, remaining connected to the internalized attachment relationship in the early childhood stages.

b.2. The parenting style of emotions socialization

Direct socialization of emotions is done through the parents reactions to the child's emotions, reactions that can be supportive (support, empathy) or non-supportive (punishment, avoidance) and which, subsequently, become transferable into the child's emotional life. The sensitive, supportive and receptive parents to the child's emotional experiences create an adequate context for adjusting skills learning. A series of researches highlighted the existence of a relevant *emotional core* for the development of the common problems internalization (fear, sadness) and externalization (fury) forms, (Klimes-Dougan, 2007; Zeman, 2010).

Parents have the greatest influence in the social and emotional development during early childhood (Zeman, 2010) but also in adolescence. Parents' supportive reactions to the children negative emotions allow it not only to explore the emotions and events around him but also to learn how to regulate the emotions and understand the upsetting situations (Baker, 2010). The family's healthy emotional interactions become a resource in the child's and teenager's fury regulation who also live in risky communities (Houltberg, Henry & Morris, 2012).

What strategies do the parents use when their children express emotions?

Malatesta – Magai (1991) suggested a model that delineates the parents' currently used strategies for direct socialization of the discreet negative emotions, strategies that interfere with children ability to regulate their own emotions and subsequently with their emotional development. Five strategies typically used by the parents in the child's emotions socialization are delimited: *reward, punishment, avoidance, negligence* and *amplifying*.

a. No matter of the emotion you express I stand by you! A *rewarding* answer is a supportive one ensuring comfort, empathy and helps the child solve its problems. It consists of a set of parental behaviours which mean caressing the child when it is sad, empathizing with the child when it is furious or assisting it in a frightening situation. All these behaviours provide the child an affective comfort when it experiences negative emotions.

b. If the emotion is negative let's forget about it!

By the *avoidance* type answers, the parent tries to remove the emotion by distracting the attention and directing the discussion outside the emotional zone.

c. If your emotion is negative I do not agree with you expressing it! The *punishment* type answer discourages emotional expression by disapproving messages (e.g the child is told to be ashamed when it is furious or that it is shameful to manifest your fear).

d. if you feel a negative emotion, I will feel it more! The amplification implies an equal or superior answer as intensity by comparison with the child's experienced and expressed emotion (e.g. the parent becomes itself sad when the child expresses or shows sadness).

e. Your emotions are not important to me! Negligence means ignoring the child's emotional expression (Silk, J. et al., 2011).

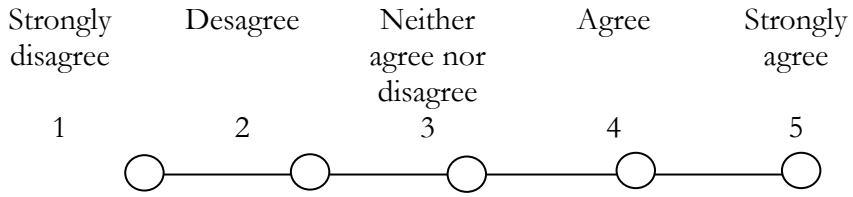
From this model's perspective, the parental facilitator answers for adequate emotional expression involve reward and amplifying, while punishment, negligence and avoidance are emotionally inhibitory strategies. Amplifying acts as a punitive strategy for fury but not for the internalization emotions and for the positive ones. Reward and amplifying facilitate positive emotions (Garside, 2003).

c. Assessing parenting style

Quizz

MESQ

Take some minutes to fill in the questionnaire below in order to find out your emotional parent style. Read each affirmation below and evaluate your agreement by putting the number that describes you in the right column.



No.	Affirmation	My agreement
1.	Sadness is something that one has to get over with, to ride out, and not to dwell on.	
2.	I prefer my child to be happy rather than overly emotional.	
3.	I help my child get over sadness quickly so that he/she can move on.	
4.	I try to change my child's angry mood into a cheerful one.	
5.	Childhood is a happy-go-lucky time, not a time to feel sad or angry.	
6.	When my child is angry, my goal is to make him/her stop.	
7.	When my child is sad, I am expected to fix the world and make it perfect.	
8.	When my child is angry, it's an opportunity for getting close.	
9.	When my child is angry, I take some time to experience this feeling with him/her.	
10.	When my child is sad, it's time to solve his/her problem.	
11.	When my child is angry, I want to know what he/she is thinking.	
12.	Anger is an emotion worth exploring.	

13.	When my child is angry, it's time to solve his/her problem.	
14.	When my child is sad, it's time to get close.	

Count your responses for the first seven questions and put it in the EC score cassette

Count your responses for questions from 8 to 14 an put it in the ED score cassette

Which one is bigger?

EC score	*ED score*

Your bigger score indicates your emotional parenting style. You can find below more information about this style.

Emotion Coaching Parenting Style: parents' awareness of emotions within themselves and their children, parents are aware of their own emotions, are sensitive and aware of these emotions in their children, are empathetic and assist their children with their negative emotions (Gottman & Declaire, 1997; Gottman et al., 1996, 1997, Lagacé-Séguin & Coplan, 2005). They consider negative emotions as an opportunity for intimacy and spend more time with a sad, angry or fearful child. They help children to label their emotions and offer guidance in regulating them. This form of parenting is associated with emotionally competent children, higher self-esteem and more positive relationships (Gottman & Declaire, 1997).

Emotion Dissmising Parenting Style: a diminished ability to deal with their or children's emotions, emotionally out of control feelings, ignore or dismiss negative emotions, consider that negative emotions are signs of lack of parenting skills. Children raised by these parents believe that their negative emotions are inappropriate (Gottman & Declaire, 1997).

Reflection
Return to the first 7 questions and find out what behaviour you have to develop in order to be a more emotional coaching parent than an emotion dismissing one.

Effects of the parenting strategies on children emotions socialization

The strategies the parents currently use in children's negative emotions socialization (sadness, fury, shame, fear) in different periods of their development (childhood, adolescence) leave consequences on their psychical health condition. According to the analyzed studies, an adequate emotional interaction between parent and child substantiates the emotional and social skills (Baker, Fenning, & Crnic, 2010). Instead, the accentuation of the negative emotions through the parent's inadequate answers correlates with child's aggressiveness (Mirabile *et al.*, 2009). An unbalanced emotional experience („they live too long or too little a certain emotion") creates a risk for psychopathology (Garside, 2003).

Are mother and father different in socializing children emotions?

The parenting style is influenced by the *parents' gender*. At the expressivity level, father's expressive equilibrium is better than the mothers'. Fathers show more happiness while mothers

express a larger variety of emotions, both positive and negative (Denham et al., 2010). With respect to the type of emotion manifested in the relationship with the child, mothers manifest more positive emotions (especially in the relationship with the girls) and more sadness in their relation to the children, generally, as compared to the fathers. Fathers, in the relationships with their children act emotionally mostly by fury (Denham et al., 2010).

Regarding the involvement in children emotional life, comparative studies assert that mothers are more involved then fathers are, thus becoming more active socialization agents in their children lives (Fivush et. al., 2000). Mother – father comparative analysis reveal significant values more advantageous for mothers regarding the attitude and supportive reactions, positive expressivity (Baker, 2010). Mothers are also more involved in coping and emotional expression management abilities development then the fathers (Bariola, 2012). There are authors asserting that fathers have more emotions socialization stereotype norms then mothers do (Cassano, Perry-Parrish & Zeman, 2007).

In terms of the two parents' involvement impact at the psycho-social development of the child, there are studies that capture significantly more powerful relationships between emotions socialization by the father and the child's social and emotional skills (Baker, 2010). Connell and Goodman (2002) did a meta-analysis according to which they reached the conclusion that fathers psychopathology is more in relation to the emotional and behavioural problems of the children then the maternal one. Paternity socialization strategies are more consciously related to the daughter's psychopathology (Garside, 2003). Father's acceptance attitude towards the sadness and fury of the child at the age of 5 years old is associated with better social skills at the age of 8 years old (Cassano, Perry-Parrish & Zeman, 2007).

Evidences of the parents' gender influence on the child's emotional development are contradictory, but the examination of the child's development without the father's involvement is incomplete (Cassano, Perry-Parrish & Zeman, 2007). This referral was done thirty years ago when the father was described as "the forgotten contributor in the child's development" (Lewis & Lamb, 2003). Although there were reported skill differences towards emotion and emotional coaching between parents twenty years ago (e.g. Gottman), although some of these data are contradictory, up to now there are quite a few clarifications. These findings leave open the way for more research aiming at solving gender differences in the emotions socialization process (Baker, 2010).

Is the parent's reaction different according to the child's gender?

The parenting response is influenced but the *child's gender* also. Parents differ regarding the sons and daughters' emotions perception: fathers perceive their sons as inhibiting their sadness more than mothers do, while mothers perceive their daughters as inhibiting their sorrow expression more than the fathers do. Mothers are more in distress when the daughters express their sorrow, as compared to the expression of the same emotion by their sons. As a concrete measure, mothers respond to the sadness emotion with a problem oriented approach. Hence, the teenager's perception are see their mothers more active and presently involved in their emotional life (Cassano, Perry-Parrish & Zeman, 2007).

In what way does the manner the parents respond to the children emotions become important on a long term?

The studies discovered a connection between the parent's emotional behaviour and the psychopathology index. Thus, the punishment of positive emotions is related to a high level of distress, while the reward for the same emotions is associated with the decreasing of the distress level (only for girls). The reward, as a sorrow and fury socialization strategy in girls, decreases the psychological distress, while fathers' responses (as punishment and negligence) enhance stress both in girls and boys. Inhibiting positive emotions may predict distress more, beyond the facilitating or inhibiting of the negative affections. This ascertainment is an argument aiming at the more attentive capitalization of the positive emotionality within the emotional education process (Garside, 2003). Beyond the emotions socialization parenting style, consistency/inconsistency becomes a predictive factor for the internalization/externalization matters (Brand & Klimes-Dougan, 2010). The affective expression of the family itself is a predicator for anxiety development in children and teenagers (Trosper & May, 2010).

d. Parenting strategies

Parenting analysed within the processual model of the emotional adjustment (Gross, 1998a, 1998b, 2002) highlights the time dimension in this process (Gyurak et al., 2011). Built as emotion's modal model (Gross, 2007), the processual model underlines five points in which the individual can adjust its emotions: situation selection, modifying the situation, attention movement, cognitive change and answer modulation.

Before activating ourselves strategies of the emotional adjustment through the confrontation with situations and life events every day, they were seen, imitated, exercised, positively or negatively strengthened in the family. Family environment is built on the nature of emotional adjustment strategies which parents activate in their daily experiences.

• *Situation selection,* the first temporal activated strategy in the process of emotional adjustment, defines family context through the way parents allow the involvement in the family environment of different activities bearing emotional messages. For example, the families where there are members with affective disorders as depression will engage less in pleasant experiences and will develop more chances to raise children having a hard time adjusting their negative emotions. In addition, the children of these families will have limited access to meet pleasant and tonic events from an emotional point of view. The situation filtering pattern which applies in these families paints to the child a grey world, towards which there are activated emotions from the negative register (fear, sadness, fury) generating, further, internalization and externalization symptoms.

• *Modifying the situation* reveals the parent's instrumental role who intervenes and modifies the situation in the direction of a desirable emotional answer of the child (from the parent's perspective). Mostly, parents modify the situation in order to protect children from experiencing some negative emotions. This seemingly positive behaviour, hides subsidiary negative consequences on a medium and long term: blocking the autonomy and independent child development. McLeod, in a meta-analysis, highlighted the link between parental control and teenagers' anxiety disorders (Trosper et al., 2009). In addition, the children of the families with depressive parents do not have access to modification strategies for the stressful situations.

• *Attention orientation.* Parents may try different attentional strategies to protect their children from aversive emotional stimulus: distracting attention or the conversation with a stimulus interpretation as flexible as possible.

• *The cognitive change* is a strategy on which parents interfere in three ways: (1). the information the child gives when it is confronted with the emotional circumstances, (2). the causal explanations of the different emotions and (3). Rules of the emotions in the context of the social interactions (Thompson, 1994).

• *Response modulation.* Studies regarding the parent – child interaction highlights the fact that the parent's attempt to influence the child's emotional expression, to limit or supress the expression of the negative emotions, may contribute to the psychopathology internalization. On the contrary, the parent's support in the child's emotional expression leads to the acquirement of adaptive emotional adjustment strategies. A mother's denigrating answer to the child's emotions is associated to the development of an avoidant coping, strategy engaged, unfortunately, in anxiety development. Otherwise, the families with depressive members are less open to emotional expressivity (Trosper et al., 2009).

Reflection
Analyse the behaviour you had with your child in the last week.
Which of the above mentioned strategies were more frequently used?
Could you do a hierarchy of them regarding their frequency?

5. Where can you find assistance and ask for special help in parenting area?

European Parents' Association (EPA) http://euparents.eu

CoFace- Families Europe http://www.coface-eu.org/

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2. Helping the child build social skills

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Chapter summary:

This chapter will be addressing some of the important points of improving social skills in children with special needs. First, the definition of social skills will be provided. Second, social skills that help children build relationships in social life will be listed. While doing so, some parental practices will be stated to build social skills in children. Following will be the provisions of some of the resources that could be found through internet or in printed materials. In addition to the information on social skills, parents will find some practices throughout the text. Those practices will help them develop some practical knowledge to use when they aim for assisting their children. The chapter is formed by addressing three main parts: (a) Building positive relationships, (b) Building communication skills, (c) Listening empathetically and validating the child's feeling.

Introduction

Widely accepted definition of social skills is provided by Gresham and Elliot (1984) as "Socially acceptable learned behaviors that enable a person to interact with others in ways that elicit positive responses and assist in avoiding negative responses" (p.293). Facilitation of an interaction while using verbal and nonverbal communicative tools is another definition. However those interactions cannot be thought without any roots, connections, or contexts. Social acts need to be based on socially acknowledged rules. Thus, these acts require many skills that are in help of individuals' endeavors to be a part of a variety of social groups. The below list provides a comprehensive understanding of social skills that people use while engaging in meaningful social acts. The presence of (or lack of) skills might ease (or make it hard) to build and continue good relationships with others.

- Understanding own and other's feelings
- Expressing own emotions
- Giving suggestions
- Sharing
- Taking turns
- Helping others
- Giving compliments
- Giving apologies
- Saying 'thank you'
- Showing empathy
- Sensitive to others' feelings

- Acting cooperatively in a group
- Contributing to a team work
- Supporting good decisions
- Expressing her/his expectations

Practice: First, observe your child's behaviors by using the above skill list. Make your observations in a variety of settings and with different people. How is s/he using those skills when s/he is at home, at school, with you with her/his teachers, friends? How about under stress? Is it easier for her to show compliance while she is relaxed or vice versa? Take notes while making observations. Compare and contrast the differences in her/his behaviors. The aim of this practice is to make sense of your child's social behaviors. Having this understanding will help you assist your child building positive relationships.

Children are easily labeled by adults as being naughty, rebellious, or non-compliant. Knowing the child helps adults avoid those generalizations. Showing biases towards children as being unable or unskillful of presenting socially acceptable behaviors is not helpful. Instead, adults need to act as an agency that the child use to acquire social skills to build positive relationships with others. Some of the examples are provided in the following table to help parents change their view of some personal characteristics. Changing the perceptions of some character traits is helpful to work on developing socially accepted behaviors.

Table 1. Changing perceptions

Negative perception	**Positive perception**
Rude	Honest
Hyperactive	Energized
Destructs easily	Paying attention to things
Acts a lot	Busy
Hesitated	Thinks before takes action
Selfish	Knows what s/he wants
Stubborn	Independent
Difficult	Excited
Sensible	Sensitive

a. Building Positive Relationships

The most essential part of being a parent is to help your children to socialize. Guiding them in social interactions by role modeling might be one of the techniques that parents use intentionally or unintentionally. In social life, parents' interactions with other people are watched by children to learn how to act in similar situations. How their parents say 'hello' and 'goodbye' when they see someone will be copied by children and will be saved as future references in their relationships. The routine of social interactions and relationships in social life will be best learned

by observations. However, modeling is not the only strategy to teach and observing is not the only strategy to learn social skills.

Modeling is categorized as indirect teaching. However, modeling by itself may not be enough and cannot be the sole strategy. Moreover, it may not be even preferred in the cases where adults do not behave in proper ways. For instance, if a parent is having difficult times controlling her/his anger and damaging people's feelings may not suit well as a good role-model. However, as being the closest person in a child's life, the child may not have an option other than following his father's and mother's steps. Thus it is crucial for parents to self-check their abilities to form relationships, use positive communicative tools, and show empathy to others. Table 2 shows the skills that people should have in their relations.

> ***Practice:*** Please fill that in by considering if you and your child have those skills and to what extent that you and your child have those. It is important to remember the times that you show those skills and some difficult times that you could not. What were the inner and outer obstacles for you? What helped you to use your skills? Are there some skills that you think that you do not have at all? What would assist you to acquire those skills? How about your child? Is there any connection between the skills you have and her/his has? Why? How could you assist your child if you have some limitations yourself?

Table 2. Self-check points/ Some of the skills that we all need to have to develop relations

	How much do I have ….?			**How much does my child has ….?**		
	A lot	Some	Not at all	A lot	Some	Not a lot
1. Initiating relations with others						
2. Giving compliments to others						
3. Managing behaviors						
4. Conflict resolution						
5. Responsive decision making						
6. Managing anger and frustration						
7. Problem solving						
8. Recognizing emotions expressing emotions						
9. Regulating emotions						
10. Giving and taking directions						
11. Recognizing biases and transforming them						
12. Showing responsibility						
13. Dealing with the consequences of own behaviors						
14. Showing empathy						

Fortunately, there are variety of ways to help children build social skills other than modeling. Direct teaching is recommended by the experts in the area of social-emotional

learning. Although teaching as a verb is not preferred by some of the experts, guiding, supporting, assisting or helping might be favorable verbs. However, using teaching here has a point especially when we consider children with special needs. Parents need to be intentional while teaching social skills. The pioneering work was done by Haring and his colleagues in 1978 to identify stages of learning. At his time, he identified 4 stages, acquisition, fluency, maintenance and generalization. Later, the fifth element was added by different experts, called flow, problem solving or adaptation. The importance of this structure is helping parents and teachers construct their teaching when a child faces with a new concept or skill. Table 3 provides an example to show how a certain skill would be developed.

> ***Practice:*** Keep in mind that acquisition of any given skill might take longer for a child who has a special need. Consistency is crucial when your child tries to show his/her newly developing skills. Your support will encourage her/him during the process. Have a look at Table 3 and think of a skill listed on page 5. Write down the stages on the table.

Table 3. Stages of learning

Stages of learning	Skill	Try yourself…..
Acquisition	Child learns under what conditions s/he needs to say `thank you`	
Fluency	Child uses `thank you` if s/he receives a favor or material from someone else.	
Maintenance	Child uses the skill under the supervision of an adult	
Generalization	Child uses the skills at school, at home or in other settings	

b. The Strategies to Teach Social Skills

In order to teach social skills following the stages stated in the previous section is important. Additionally, being aware of many strategies to teach social skills in children and using them intentionally is another important point. Most of the time what adults do is preaching about how to be a good person. 'Behave nicely to people', 'Do not talk back to your elderlies', 'Do not lie'….Those advices are to teach children some social manners or to teach moral behaviors. However, those sayings are not helpful to teach children proper social behaviors especially when they are young and not understand what it is being told because of the ambiguity or abstractness of the talk. Parents need to use concreate strategies that are easily applicable.

Children are inexperienced. Because of their lack of experience, children do not know how to behave in certain social situations. Most of the contexts children are in might bring new behavioral requests from them. Due to the limited behavioral repertoire, children might show challenging behaviors in social contexts. Other than not knowing how to behave differently in different contexts, children experience hard times to identify people's emotions. They might also later develop an understanding of their power over making an effect on other people's emotions.

Thus, it is crucial to reinforce their appropriate and socially accepted behaviors. The strategies provided here might help parents encourage their children to show expected behaviors.

1. Focusing on the positive behavior: Children learn best when behavioral expectations are set and expressed positively. Adults usually give warnings to children such as 'do not talk like that', 'be silent', 'do not run'. However those warnings do not guide children to show expected behaviors. Instead of saying what not to expect, adults need to tell children what their expectations are. Table 4 shows some of the expectations expressed in a positive way.

Table 4. Positive expectations

Do not say	**Do say**
Don't run	Walk
Don't yell	Use your inside voice
Don't curse	Use nice words
Don't talk	Listen
Don't take your sister's toy	Take a turn Share
Don't hit	Use nice touches

2. Having a family ethos: Preparation of an agreement with children by stating family values might be a helpful tool to establish and reinforce expected behaviors. The question that is answered is: How other people should perceive you as a family? What are the personal qualifications that you have to follow the family ethos? What are the ways to develop social skills to reach out for the ethos? How would you get help for family members to support you developing necessary skills?

First define your family values before you start discussing your ethos. Trusted, fun, respectful... Following is an example:

'We are good people who are considered, passionate and respectful. We behave in ways that make ourselves happy and other people happy. When we do something that affect others in a bad way, we give our sincere apologies and try to make things better for them. We give importance to other people's emotions. We give suggestions to people and we take feedback positively. We always tell the truth no matter what the consequences are. We are trustful. That is who we are!'

3. Not having too many behavioral expectations: Children might get confused if there are too many expectations of them. Moreover, it might be difficult to remember and follow each. Consistency might be another challenge for children. It may take time to be consistent demonstrating the expected behaviors every time and in every context. Thus limiting expectations based on the child's age and developmental level and introducing a new expectation each time s/he seems to be ready for a new challenge are the principals to follow. These principals will ensure that children follow the set expectations and will receive constant positive reinforcements due to the manageable nature of the short list.

4. Catching them being 'good': Another important point is to give a reinforcement at the time when children behave properly. Monitoring and warning children for bad behaviors are not effective ways. Having unrealistic expectations is something that needs to be avoided. Providing positive reinforcement immediately when the expected behavior is presented is crucial while guiding children.

5. Encouraging by giving constructive feedback: 'Well done' and 'Good job' are not specific feedback. Children would not know what they are encouraged for. Thus, the significance of showing positive behaviors should be explicitly identified. Not giving any reference to the past or the future is another important point. `Next time do not forget to do….' is not helpful neither is 'Now you did this but you had forgotten to do it yesterday'. Instead of reinforcing the full performance, the process needs to be cherished by adults. The importance of taking steps for the planned outcome should be emphasized more. Following are the examples:

- It has been going well.
- You did it by yourself.
- I am proud of you because…
- You pay attention to…That is very helpful.
- Your efforts payed off.
- Your drawings improved a lot.
- You gave a %100 to improve …
- You helped a lot to …
- You solved the problem.
- You cared a lot about this. This is very important.

6. Having a mascot: The mascot is a stuffed animal that sets an exemplary model to a child. The mascot has all the values that are wanted to be acquired by the child. However those values need to be concretely exemplified by addressing certain behaviors. The child could be led to the mascot whenever s/he needs suggestions or guidance whenever s/he feels inaccurate to solve her/his problem. The advantage of having such an exemplary persona around might lift some the weight from adults' shoulders to provide solutions to socially awkward situations. At the same time, it breaks the hierarchical understanding of children who believe that adults know better than children and they solve all the problems on behalf of them.

c. Listening Empathically and Validating Feelings

The basic needs in social relations are to understand people's thoughts and feelings and to be understood by other people. The best tool to meet those needs is communication. However, communication is mixed up with talking most of the time. However talking might be the less effective part of communication. Instead, listening skills are to be improved to become a good converser. The following table and practice are presented to help for being a part of an effective communication process. Table 5 provides the basic components of a bad and good listener. In order to understand the basic listening strategies, it is important to evaluate the behaviors we possess when we communicate with others.

Table 5. Bad listeners/Good listeners practice

Bad Listeners	**Good Listeners**
Criticize, suggest, warn…(not listen)	Passive listening
Look away	Make a constant eye-contact
Engage in other things	Engage in the conversation by nodding
Give more attention to herself/himself (think	Give full attention to the converser

about the things s/he will say when takes turn)	
Ask irrelevant question	Ask questions if needed

Thomas Gordon who is one of the pioneering psychologists in the area of human relations training provided two effective strategies in communication: Active listening and I messages (i.e., I messages will be presented on page 16 under the title of Positive, Effective, Nonviolent Communication). Gordon (2003) suggests that passive listening (silence) needs to be used to give some space for the person who tries to express her/his thoughts and ideas. He states that silence by itself might not ensure an interactive/two-way communication. The person who is talking may not understand if s/he is getting the full attention or the person who is silent fully understands what is being told. Gordon presents 'acknowledgement responses' and 'door openers' while communicating as helpful strategies. Acknowledgement responses could be both verbal and nonverbal. Nonverbal acknowledgments are smiling, nodding, leaning forward, frowning, any body movements that give a message to the other person that s/he is being listened. Some verbal cues of an effective listener are 'Uh-huh', 'I see', 'I understand'. Door openers are also effective for encouraging a person who is hesitant to continue the conversation. Some door openers are "Can you tell me more….", "That sounds interesting, you want to talk more about this?".

Although the three strategies explained above are helpful, Gordon suggests using active listening in order to show empathy. One of the reasons people communicate is to carry out messages such as I am tired, I am hungry, I am annoyed. However, instead of saying those needs and feelings directly, some indirect messages are carried due to the fears of being judged, ridiculed, or criticized. Thus active listening provides ways to understand the real needs and emotions hidden by some messages. Some examples of how to engage in active listening are provided in the boxes of communication:

Child: I don't have time to get prepared for grandma's visit
Parent: You feel that you are being rushed.

Child: I cannot complete my homework
Parent: You think that you don't have enough time

Child: I hate Jordan, he always tells me what to do!
Parent: You don't like being told what to do.

Lastly, the benefits of active listening as listed by Gordon are listed below.

1. Helping children deal with and defuse some strong feelings
2. Assisting children understand that they need not be afraid of their emotions

3. Helping children focusing on the real concerns not on the 'superficial problems'
4. Encouraging children taking the responsibility of solving problems
5. Having children cooperating more with adults
6. Facilitating having mre meaningful and genuine relationships with peers and adults.

d. Positive-Effective-Nonviolent Communication

In his teachers (TET) and parents effectiveness training (PET) books, Thomas Gordon presents twelve communication barriers. It is crucial for parents to understand what they do wrong when communicating with their children and learn how to replace those ineffective habits with the effective strategies such as Nonviolent communication and I messages that will be the next section under this title.

The twelve communication roadblocks as Gordon stated are listed below. Interestingly, although some of them obvious such as threatening, ridiculing, and being sarcastic, some of them seem not to damage communication like reassuring, giving facts, and agreeing. Gordon explains how those pursue a similar message that is putting down the ability of a child to solve problems. He also states those responses almost always lead to non-compliance behaviors accompanying with anger, resentment, and frustration. Additionally, those responses take away the opportunity of showing and receiving empathy which is the base of good relationships.

1. Ordering, Commanding, Directing
2. Warning, Threating
3. Moralizing, Preaching, Giving 'shoulds' and 'oughts'
4. Advising, Offering Solutions or Suggestions
5. Teaching, Lecturing, Using Logic, Giving Facts
6. Judging, Criticizing, Disagreeing, Blaming
7. Name-calling, Stereotyping, Ridiculing
8. Interpreting, Analyzing, Diagnosing
9. Praising, Agreeing, Giving Positive Evaluations
10. Reassuring, Sympathizing, Consoling, Supporting
11. Questioning, Probing, Interrogating, Cross-Examining
12. Withdrawing, Distracting, Being Sarcastic, Humoring, Diverting

(Gordon, 2003, pp. 79-89)

Marshall Rosenberg (2003) who is the author of Nonviolent communication (NVC) inspired many people to use effective communicative strategies. He emphasized on the importance of using NVC under stressful conditions when feeling anger and frustration. First of all, in order to use effective communication, it is crucial to recognize emotions before acting upon the stressful situation. Second, calming down by using breathing techniques provides great help to start effective communication. Such efforts would bring back our rational side of thinking. After these steps are taken, NVC would be used. NVC has four components. The first component is observation. When communicating about the conflicting situation, providing an observation that is objective might be helpful. Second component is expressing emotions. That is the part of NVC when a person expresses her/his feeling to the person whose behavior caused

the feeling. Third component is expressing the need and fourth is sharing expectations. As an example, let us assume that the child is not tidying up her/his room. The mother says "I have observed that three times this week you have not cleaned up your room. That makes me sad. I need your room clean and orderly. Shall we do a schedule for you to remind you to clean up?". Following is the structure of the NVC talk.

NVC structure

Observation-Feeling-Need-Request

Observation: «When I see...»

Emotion: «I feel...»

Need: «because I need....»

Request: «Want to try...?»

NVC: A simple version

Emotion-Incident-Expectation

I feel_____ (emotion)

Because_____ (incident)

If it was_____ I would have been better. (expectation / the change you want)

Practice: The below example is provided for you to practice using NVC under some challenging conditions. Please write down the situations that you feel frustrated and how you would communicate by using NVC with your child.

Table 6. Using NVC

Behavior	NVC
Your child does not respond to your request.	
Your partner does not come home early to take care of your child.	
Your child does not eat her/his meal.	

Another good strategy provided by Gordon (2003) is using "I" messages. As Gordon stated 'You' messages are to put all the blame on others. However as presented earlier, one of the aims of communicating with other people is not to blame them but to express one's needs and feelings. Thus it is a good strategy to keep the purpose of being understood while communicating. The benefits of using I messages are (a) to promote the willingness to change, (b) to share the responsibility of being a part of the solution, (c) to keep the relationship genuine. The following practice is designed to assist parents using I messages when communicating with their children.

Practice: Please read the below examples and make a connection with the situations that you find yourself in while communicating with your child. How do you use "You" and "I" messages? Any difficulties using "I" instead of "You"? Why are "You" messages being used easily than "I" messages? Under what conditions it is easy for you to use I instead of You and vice versa. Add some examples.

- I don't support the idea of riding a bike without a helmet on
- You insist on riding your bike with a helmet. That is an irresponsible behavior.

- I feel that I am taking all the responsibility of making sure that your homework is done.
- You forgot to do your homework again. I will not warn you next time.

- I am frustrated by the noise.
- You make too much noise.

- ?
- ?

Conclusion

The chapter started with some definitions of social skills and the list of the social skills that adults and children should have to have quality relationships. Learning how to behave properly might be by observing other people's behaviors or by direct teaching. Some strategies to teach social skills to children are shared in the following section. Communicating effectively has the biggest role when people engage in social interactions to build relations with others. Thus some strategies such as active listening, I messages, non-violent communication are provided as ways to engage in non-judgmental and full-acceptance ways of communication.

Internet and/or Printed Resources

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3. Helping the child build emotional skills

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Chapter summary

The main purpose of this chapter is to bring the population – and especially parents – closer to the world of emotions, in order to help them understand the role emotions play on our daily basis. In addition, it is also intended to provide activities and resources in order to be able to understand and work the concepts posed in this chapter.

Emotions are and will always be present throughout our lives, and consequently, it is necessary to understand them and know how to regulate them adequately for them to contribute to our welfare. Educating emotions, or in other words, the emotional education is based on the development of emotional competences that allows favouring the comprehensive development of people, and therefore, the social and personal well-being.

Emotional competences can be classified in five different groups: emotional awareness, emotional regulation, emotional autonomy, social competence and competences for life and well-being (Bisquerra & Pérez- Escoda, 2007). All of them include micro-competences such as, self-esteem, resilience, empathy, among others.

The competences are understood as a body of knowledge, capacities, abilities and necessary attitudes to become aware, understand, express and regulate emotions adequately. The final purpose of all five competences is to improve professional tasks and foster both the social and personal welfare, since it contributes to the adaptation in the social context as well as the challenges that life may pose.

The first step needed for an appropriate emotional health is the one of emotional awareness, since it allows us to take notice of our own emotions and therefore, act on them. Subsequently, it is needed to learn and deal with these emotions appropriately. At this stage, it is needed to make use of the previously called emotional regulation. Finally, self-management – emotional autonomy – and the social competence are needed because they consist of maintaining good relations with others and people that surround us. Lastly, life and welfare abilities are the responsible ones to adopt an adequate and responsible behaviour to cope with any situation throughout our life.

1. Glossary/Words to know/Definitions

Emotional Education, Emotional Competences, Self-esteem Emotions, Emotional Awareness, Emotional Regulation, Emotional Autonomy, Social Competence and Life and Wellbeing Skills.

2. You are not alone – Statistics related to children with special needs and their parents

According to *Estadística de las Enseñanzas no Universitarias,* carried out by *Subdirección General de Estadística* and *Estudios del Ministerio de Educación, Cultura y Deporte,* Spain has a total of 2.9% of students (173,797 out of 8.101.473) that requires special educational needs (see table 1).

Table 1

		Percentage
Sex	*Boys*	66.84
	Girls	33.16
Type of impairment	*Hearing impairment*	4.33
	Motor impairment	7.71
	Psychological impairment	37.39
	Visual impairment	1.84
	Developmental disorder	17.45
	Behavioural disorder	22.35
	Multiple impairment	6.01
	Others	2.91

According to the last reports, two out of three children are males and Spain is, along with countries like Luxemburg, Italy and the United Kingdom, one of the countries with the smaller percentage of students with special educational needs (SEN).

Munchin (1977) explained that any child requires a special educational attention from the moment of birth, and for this reason, when we talk about children with either transitional or permanent disabilities, it also implies an additional task which consist in maximising the quality of the children's skills.

It has been investigated and it has been concluded that impairments, either transitory or permanent, tend to be more explicit over time together with the chronological development of the child and such impairments are influenced by the daily experiences and situations of his/her context.

It has also been discovered that those who influence in the therapies undertaken by boys, girls and teenagers are the family members. Analysing this from a global perspective, the inner aspects of people are connected to the relationships that the child or teenager is experiencing on a daily basis; the reality is shaped by the permanent relationship established between the individual and the family. For this reason, parents' participation is essential to provide permanent support in the attention and development process of their children.

It is increasingly apparent the necessity that parents have to be aware of the exact situation in which the child is experiencing, which are his/her strengths and what stimulation the parents can offer his child at home. Notwithstanding this fact, this will always be accompanied by a professional group which will assess and evaluate the child's progress.

In addition, it is interesting to promote spaces for parents where they can exteriorise their worries, anxieties and doubts, where they can consider they are important in the education and care of their children. The main purpose of these spaces would be to foster the comprehensive and maximum participation of the family in the intervention and orientation process.

It is highly relevant that parents can understand in which way their child is going to construct his/her own knowledge. Any child, teenager or adult always has the opportunity to learn and

progress. However, the key idea must be found in the best way to be able to help them in this continuous learning process.

The main purpose of the cooperation between the professional team and the family is to help their children, with special educational needs (NEE), to progress, improve and lead them to a complete personal development as positive as possible.

In the Spanish legal frame "ll Plan Nacional de Educación Especial (PNNE, 1978)", families initiatives started to be coordinated, and nowadays, "Ley Orgánica de Calidad de la Educación" (2002) encompasses parents' participation and orientation towards students with special education needs.

Making a reference to the education of this type of students, there are two positions that families can adopt; in the first one, there are those parents who are worried about the fact that their child can be in an ordinary class because of different reasons such as, fear to lose grants and individual services, academic failure, the child's self-esteem and his/her frustration. Whereas the second viewpoint is the one from families which see the integration in the ordinary classrooms as an opportunity and a positive point because it may prepares their child to be independent and play a part of the society (Green y Shinn, 1994).

For this reason, it is important to respond to these necessities. There must be tools provided to families in order to be able to be informed and assess their situation, providing accessible formation and fostering the dialogue in this type of families by offering them a closer and comfortable environment for all of them. This is ratified by Abrams y Goodman (1998) with the idea that the support between parents creates a bond and a community of people with similar situations are prepared to listen and support themselves mutually, thus giving the opportunity to the families to experience equality and reciprocity.

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3. Theoretical section on the topic of our specific chapter

The entrance of a baby in a family causes significant changes in each and every possible aspect. Its upbringing and education brings, especially at the beginning, insecurity and stress, which requires a good emotional management in order to adapt to the new situation. Nonetheless, parents who have children with special educational needs (NEE) will probably find themselves in more complex situations and challenges – and more frequently – than those parents whose children have a typical development. An example would be to accept the conditions and limitations of the child, find services and specialised care, organise the future, among others.

Parents and teachers, who have children with specific needs, as it has been mentioned previously, are exposed to confront social and emotional challenges that are unique when dealing with their caring functions. Stress, an element that will appear frequently, directly affects health and wellbeing of parents and special education teachers. Currently, there are not high numbers of rigorous studies that have evaluated whether the comprehensive attention training could be a strategy to reduce stress and foment wellbeing and care for adults.

In these few studies, it has been proved how participants who have put into practice the comprehensive attention showed a certain reduction in stress and anxiety as well as the social competence was affected in a positive way. It is also important to take into account the emotional aspect since it plays an important role in the daily life of people. Thus emotions are the protagonists in the way we react when any event takes place as well as the way we cope with more complex situations.

For a long time, society has valued a concrete ideal of the intelligent person. This person had facilities with languages and mathematics. Nowadays, this vision towards intelligence has been questioned. In fact, there is proof that academic intelligence is not enough for a person to be successful both professionally and personally. Differently, those who are able to have positive relationships with others have more chances to be successful in the two aspects mentioned above. Another reason why this vision of intelligence is in crisis is because intelligence does not guarantee anybody to be successful in life, since the intellectual quotient (IQ) neither affects nor conditions our emotional balance. Instead, emotional and social skills are the ones which make us have a mental and emotional stability (Fernández, 2002).

In Delors' report (1996) there is an emphasis on the equalitarian development of the four areas of the person. *Learn to know*, in other words, acquiring little by little all those necessary tools to understand all kind of information that we receive, makes reference to the development of the cognitive area. Regarding motor skills area, Delors (1996) names it as *learn to do* and it is this pillar which makes reference to be able to react from any situation in a more autonomous way. The third cornerstone is *learn to live together*, the social area, therefore, one has to know how to participate and cooperate with others in all possible activities. The last and most essential area is to *learn how to be*, that is, the personal area, in which one progresses by participating and learning from the previous areas.

Emotions are present in the daily life of people. Bisquerra (2000) understands that an emotion is a "complex state of the body characterised by an excitement or disruption that predisposes to the action".

Another way to define emotions, according to Díez (2010), is that an emotion has to be understood as a reaction that the individual responds as an external stimulus, and that such reaction is accompanied by both neuronal and hormonal response. Emotions are always related to the atmosphere and context in which one may encounter at the moment that the reaction takes place. These actions are given due to physiological, verbal and behavioural facts. Agulló (2003) adds that any kind of emotion has a brief length, which means that can last some minutes or hours but it is really complicated that an emotion can last one or more than one day.

Given the importance that emotions have throughout our lives, it must be taken a relevant time to understand them and to know how to manage them properly. Bisquerra (2001) defines the concept of emotional competences as a combination of abilities, knowledge, skills and attitudes that come into play at the moment of becoming aware, understand and know how to express correctly the emotions that may be emerging. The development of emotional competences also facilitates other aspects of the person such as social adaptation and relationships with others as well as such competences also influence on the learning processes, in the way how to confront any daily difficulty, in the resolution of conflicts, among others.

As it has been mentioned, all of these competences contribute to develop our wellbeing both in personal and social level. Starting with the premise that a happy person does not generate conflicts, therefore, it is important to understand and be aware of the fact that we need to feel good with oneself to be able to feel comfortable with others, and consequently being happy.

In this vein, the model that encompasses all emotional competences is found in Bisquerra and Pérez Escoda's (2007) pentagonal model. Hereafter, it is going to be explained in detail what these competences are and what they entail. It has to be considered that each competence is formed by a series of micro-competences.

a. The emotional awareness is the first competence that needs to be developed further in order to be able to do the same with the other competences. This one consists in the recognition and understanding of emotions. This means that this competence involves knowing emotions – either your own or others' emotions –, acquire a wide vocabulary to name the correct emotion when it is identified as well as using verbal and non-verbal language to express all types of emotions and to become aware of the own emotional state.

The micro-competences of the emotional awareness are:

- *Awareness of the own emotions:* it is that skill to perceive accurately the own emotions and feelings, as well as identify and name them.
- *Name the emotions*: it makes reference to the efficacy that people have when using the proper emotional vocabulary and expressions in a determined cultural context to appoint the emotional phenomena.
- *Understanding others' emotions:* it is the skill to perceive accurately others' emotions and feelings, in which one can adopt an attitude of empathy towards the experiences and emotional situations of the others.

b. The emotional regulation (second competence) can be understood as the capacity to regulate (not to repress) emotions adequately, as well as becoming aware of the relationship among

emotion, cognition and behaviour. It also makes reference to have good coping strategies and to have capacity to auto-generate positive emotions, among others. In this way, regulation implies the skill to cope with negative emotions through the use of auto-regulation strategies that improve the intensity and length of these emotional states, as it has been explained in the most theoretical part of this study. In the emotional regulation it is important to have techniques such as the internal dialogue, manage negative emotions such as rage and anger or situations like stress or anguish. In other words, it is important to have a wide range of varieties to use auto-regulation emotional strategies (being able to express feelings and emotions), to know how to regulate impulses and feelings as well as being tolerant towards frustration. This competence encompasses the following micro-competences.

- *Adequate emotional expression:* it is the ability to express emotions in a correct and adequate way. In order to be able to do it must be understood that the internal emotional state does not have to correspond to the external expression, either in the personal level and other people.
- *Regulation of emotions and feelings:* it is the emotional regulation, which means that it is necessary to accept the emotions and feelings have to be constantly regulated.
- *Coping skills:* it is the ability to confront challenges and situations in which any conflict may emerge, taking into account the emotions that this situation produces.
- *Competence to auto-generate positive emotions:* it is the ability to experience voluntarily and consciously the positive emotions and therefore, to be able to enjoy life. This ability also entails the own auto-management of the emotional wellbeing in order to have a better standard of living.

c. The emotional autonomy can be understood as the capacity not to be seriously influenced or affected by the environment stimuli. It is the balance between emotional dependence and dissociation. This concept includes a group of characteristics and elements related to personal self-management and self-concept. The latter has the function to assess and recognise the own abilities and limitations. Being able to accept oneself implies that one recognises and accepts all the aspects about him/herself, that is, s/he accepts both the positive and negative aspects. The self-concept is the image one has about him/herself, and such image is needed to develop the self-esteem. In addition, this ability also takes into account the following elements as micro-competences:

- *Self-esteem*: it consists in having a positive image of oneself and be satisfied; to be in good terms with oneself.
- *Auto-motivation:* it is the capacity to auto-motivate and be emotionally involved in diverse activities of the personal, social, professional or leisure life, among others.
- *Emotional self-sufficiency:* it makes reference to the perception about what one i sable to do in personal and social relationships. One perceives him/herself with the capacity to feel how s/he likes and enjoys, that is, the emotions that s/he needs.
- *Positive attitude:* it is the capacity to have a positive attitude towards life. Feeling constructive upon oneself and upon society; feeling optimist and strong when coping with daily challenges; intending to be good, fair, benevolent and compassionate.
- *Critical analysis of social rules:* it is the capacity to assess critically cultural and social messages; those which are tied to social rules and personal behaviours.
- *Responsibility:* it is intended to be involved in safe, healthy and ethic behaviours. Taking responsibilities in the decision-making including towards attitudes that we need to adopt in life, either positive or negative.

• *Resilience:* it is to confront adverse situations that life may offer.

One can be conscious of the emotions and can even know how to regulate but if s/he does not have a decent level of self-esteem and does not regard him/herself in a positive way, s/he will not be able to address properly and assertively to another person to defend his/her own rights.

d. The social competence is the ability to maintain good relationships with other people. This implies to manage basic social skills (listening, greeting, thank people, ask permission, apologise, say goodbye…), the capacity for having an effective communication, show respect to others, pro-social attitudes, assertiveness, among others.

When we talk about the social competence, we are obliged to refer to assertiveness as the skill to defend and express one's own rights, opinions and feelings: being able to say 'no' in a clear way and standing firm despite the consequences that may derive; confront group pressure and avoid situations in which one can be coerced; delay any performance or decision making under these pressing circumstances until being properly prepared, etc.

Teaching to communicate in an assertive way generates confidence. This is the way in which the child with skills of assertiveness learns to believe in his/her own feelings, judgements, and to avoid excessive dependence from adults or other colleagues' approval. In this vein, training for assertiveness is also a tool for children to learn to resist the pressure between peers in order to do things they feel that are wrong, dangerous or that they simply do not want to carry out. The micro-competences are the following:

Control basic social skills: the first of these skills is to listen. Without this skill, it is difficult to go through the others: greeting, thanking others, turn taking, being thankful…

Respect the others: it is the intention to accept and appreciate individual and group differences as well as valuing the rights of all people.

Practise receptive communication: it is the ability to understand other people both in verbal and non-verbal communication in order to receive messages that are transmitted with accuracy.

Practise expressive communication: it is the ability to start and maintain conversations, express one's own thoughts and feelings in a clear way and prove the others that you are able to understand them.

Share emotions: the fact of sharing emotions is a difficult action to carry out since all participants need emotional understanding.

Pro-social behaviour and cooperation: it is the ability to carry out actions to benefit others, without them having asked for it.

Assertiveness: it means to find the balance and adopt a balanced behaviour between aggressiveness and passivity. This goes along with the capacity to defend and express one's own opinions, and at the same time, respect and accept such opinions.

Prevention and solution of conflicts: it is the ability to identify, predict or confront social conflicts and interpersonal problems resolutely.

Ability to manage emotional situations: it is the ability that one has when being able to redirect emotional situations in social contexts, that is, to activate collective emotional regulation strategies.

e. The last competence would be the **life skills and wellbeing**, that is, to develop that skill to carry out appropriate and responsible behaviours to problems that may affect directly or indirectly to you, either they are personal, familiar or professional problems or problems originated from society or the current context. Life skills and wellbeing make reference to all those abilities and

resources to confront and overcome any kind of problem or conflict that can emerge on a daily basis. These resources help organise personal life in a rewarding way, and at the same time, it can contribute to one's wellbeing as new positive emotions are being experienced and discovered.

Delimit adaptive objectives: it is the ability to set positive and realistic objectives, either in the short-term or long-term.

Decision making: it is to develop personal mechanisms to make decisions by making that these decisions do not affect personal, familiar or academic situations.

Seek help and resources: it is the ability to detect when one needs assistance and knows how to access to available resources that are more adequate.

Active, participative, critical, responsible and compromising citizenship: it implies the recognition from one's own rights and duties; the development of the group membership feeling; the acquisition of an active participative attitude and the respect towards multicultural and diversity values.

Emotional wellbeing: it is the ability to enjoy and consciously take advantage from the personal, emotional and psychological wellbeing, as well as trying to transmit it to people from your surroundings.

Fluency: it is the ability that allows generating optimal experiences in professional, personal and social life.

All these competences do not perform as self-contained areas but they are interrelated. Consequently, the classification in five blocks allows us to work on them in a more systematic and conscious way.

f. Emotional regulation process

It is important to teach all these competences because, in this way, we will become emotionally intelligent, which means that we will be aware of our own emotions and we will know how to recognise others' emotions, as well as being able to regulate such emotions on our side to make productive and constructive decisions.

It also has to be emphasised how to solve conflicts properly but before it must be understood what a conflict is. A conflict is a situation that is produced when two or more people are in disagreement because of their interests, necessities or incompatible values, and where emotions and feelings play a decisive role.

Several inquiries, especially in the neuroscience field, praise the previous idea that emotions play an important role and are important in people's life when making any decision about our way of acting, and therefore, they are also important in the resolution of conflicts with which we are experiencing on a daily basis.

It can be confirmed by scientific and empirical studies that conflicts cam be better explained by a bad management of emotions, both individually and collectively, than rather aggressiveness or behavioural variables per se.

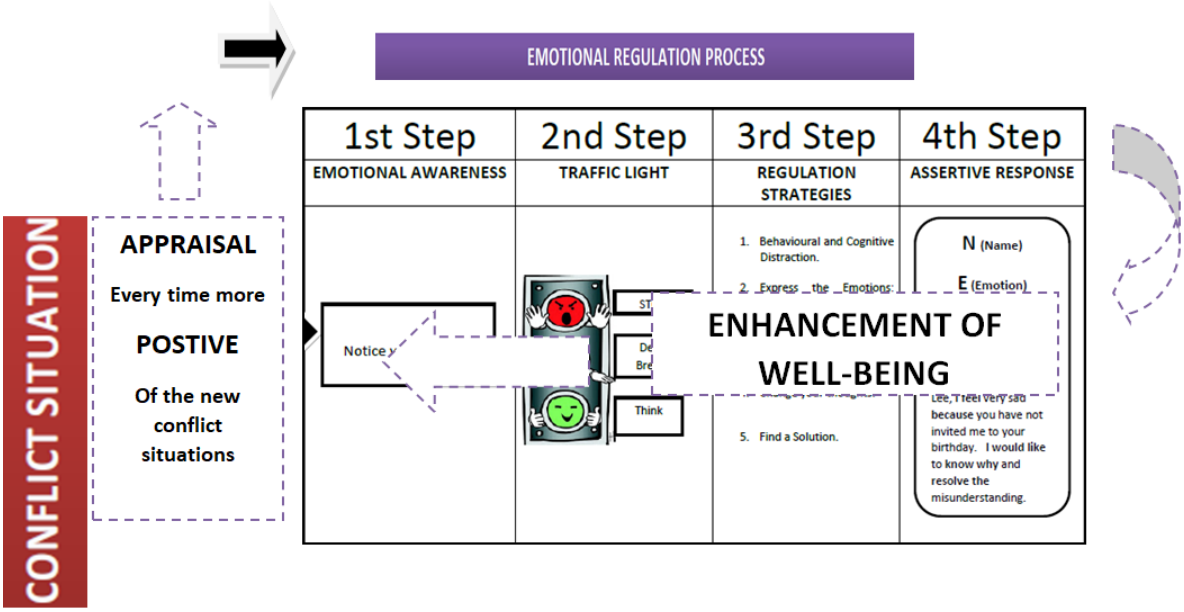
All this is related to the emotional regulation competence. In order to be able to conduct a positive conflict resolution, and subsequently, having a positive emotional regulation in place, there must be a process to follow. This process consists of 4 steps, and once all of them are achieved successfully it can be considered that the conflict has been solved assertively.

In the emotional regulation process it is perceived, recognised and understood that the person is involved in a conflictive situation and therefore s/he has to find a solution to put an end to this circumstance. The traffic light technique can be used then, which means that before taking

action one has to do a brief pause, breathe deeply and once these steps are done one can think of alternatives to solve the problem.

Hereafter, regulation strategies have to be put into effect, that is, to take these emotions into consideration and getting distracted by doing other things, explaining them to another person who is not involved in the conflict, initiating a cognitive restructuration – changing the way of thinking, changing the viewpoint – and finding the most adequate solution.

Finally, a response has to be given by using NEMO (name, emotion, motive and objective), for example: Anna, I feel sad because you have not let me play with your toys; I would like to know why and find a solution.



Some of the most important micro-competences in the positive development of the person are self-concept and self-esteem, which are concepts that are related between them but differences between them must be taken into consideration. Self-concept is the image that each person envisages about him/herself and this image is necessary for the development of self-esteem. Self-concept implies being aware of one's own skills as well as one's own limits. Whereas self-esteem is the concept we have about ourselves according to our own appraisal, that is, an appraisal based on subjective attributes influenced by experiences, both positive and negative, throughout our life, experiences, person's context, among others (Sanz, 2007).

Self-esteem is an emotional dimension while self-concept is a cognitive dimension. According to Bisquerra (2001), self-esteem means having positive feelings towards oneself and confidence in one's abilities to cope with challenges that life poses.

On the other hand, Branden (1989) defines self-esteem as a evaluative component of the concept of oneself. But, what do we mean when we talk about self-concept? It consists of what and who we think when, consciously or unconsciously, our physical and psychological features, our strengths and weaknesses, and above all, we find our self-esteem. This concept is definitely key to understand ourselves and understand but it is also the key for success and failure.

Branden (1989) divides self-esteem into two components: feeling of personal ability and feeling of knowing how to stand up for themselves. It is the sum between confidence and the respect for oneself. Self-esteem reflects the implicit judgement that each person makes of his/her own ability and capacity to be able to confront different situations that life poses, and the right each person has to be happy, respect towards his/her interests and necessities, and consequently, defend them in any situation.

In terms of self-esteem, it is necessary to develop the ability to make one believe in him/herself that is competent to live in a society that surrounds him/her, that deserves to be happy, and in this way, confidence emerges to confront life, to be more optimistic towards oneself, which allows us to achieve our goals in a better way (Steinem, 1992).

Developing self-esteem is to broaden our capacity to be happy. It is not necessary to reach a level in which we feel inferior or hate ourselves to take notice of the concept of self-esteem. This concept opens many possibilities in our life, we tend to be more creative, but above all, we tend to be more open-minded to face all kinds of problems or challenges that may arise (Branden, 1989).

According to Steinem (1992), in order to improve our self-esteem, it is necessary to carry out an exercise of deconstruction and inner personal reconstruction, since in this way we get to know ourselves better and we have a more real and positive perception of what we are and what we can become.

A perfect person does not and will never exist. Although a person can have diverse imperfections and errors, it is important to maintain a high level of self-esteem. Most of the times, it is necessary to be somewhat permissible with ourselves as well as with people that surround us. In many situations, we always have to leave room for a second chance, both for us and other people. To give a second chance to another person, it is important that you do the same with yourself (Nuñez, 1995).

Emotional education proposes the development of self-knowledge and self-esteem as requirements that permit an emotional self-control, the avoidance of negative emotions, the development of positive emotions, and consequently, the development of happiness (Nuñez, 1992).

Lastly, it is important to highlight that self-esteem, at any level, is an intimate experience, which lives inside us (Steinem, 1992).

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4. Where can you find assistance and ask for special help? Special Education Services

The educational system in Spain, covered by the law regarding the improvement in the educational quality (LOMCE, 2013), disposes of the necessary resources in order for students with special educational needs (NEE), either temporal or permanent, to achieve the established objectives in the general programme for all students.

Schools in Spain have enough resources to be able to help children develop comprehensively. Having such resources does not mean that the school has to face all these problems alone, but it is important to have different specialised teams or cross-working groups to be able to adapt to the students' necessities.

Having autonomy in the different autonomous communities entails that each of them have similar specific services with little differences among them. It is necessary to strike the fact that in Catalonia, there are two ways to achieve this kind of services: on the one hand, one of the options is to have access by means of the paediatrician, when s/he has detected any alteration or any difficulty that may derive the child to that specialised service; on the other hand, a second option is to have access by means of the school. In this second case, it is the teaching staffs that detect the necessity to receive external assistance in order to improve the development of the child or teenager. The school conveys the message to EAP and professionals from this institution are the ones who assess and derive the child to a special centre.

Now, we are going to deal with these services and what functions they cover.

• **EAP (Educational Psychology Teams):** teams formed by professionals from different fields in order to give support to teachers and educational centres in response to students with special educational needs and its families.

• **CDIAP (Centre of Child Development and Early Attention):** aimed at children between 0 and 6 years old who have normal conditions but do not reach the adequate development according to their age; or children who present clear malformation, cerebral injuries, amongst other anomalies.

• **CREDA (Resource Centre for People with Hearing Impairments)**: provide support in educational centres in the adaptation to students' special needs with serious hearing impairments, language and/or communication that interferes their personal, social and curricular development. This service works with the child, the school and the family.

• **CREDV (Resource Centre for People with Visual Impairments):** it is the specific educational service that, in cooperation with ONCE, support teachers' task with regard to serious visual impairments, and moreover, it offers direct attention to these students as well as offering orientation to families.

• **CSMIJ (Child and Juvenile Mental Health Centres):** these are centres that offer orientation, diagnosis, treatment and monitor people who are affected. All children and teenagers who have any mental disorder have access to this service until they are 18.

• **EAIA (Infant and Adolescence Assistance Team):** these are teams that provide attention to the cases in which the child is at risk of being unshielded that are detected by basic social services. One of the main tasks is to do the diagnosis, the assessment of children or teenagers together with their social and familiar environment by proposing corrective measures in every case.

• **HDA (Day Hospital for Children and Adolescents):** it is a part-time hospitalisation unit that provides intensive treatment without dissociating children or teenagers from their closest familiar, social and educational environment.

• **SEETDIC (Specific Educational Services to assist children and adolescents with Developmental Disorder and Behaviour):** these are services that provide support and counselling to Infantile, Primary and Secondary schools. Children, teenagers, together with their families, schools, teachers and EAP are the intervention areas.

In this way, it can be observed how there a wide range of options in Catalonia to be able to respond to children, teenagers with special educational needs (NEE) as well as their families, but NOT at a university level.

5. Resources for parents

Nowadays, at an official level, there are no resources for families with children with special educational level. Logically, not disposing of these tools and assistance for families entails that there is no adequate offer for the necessities for these groups, despite being necessary to give a response to this situation.

The previous claims serve as a basis for the project, in order to be able to analyse the situation in a concrete way and be able to work on it to modify it, providing resources and useful tools for families with children with special educational needs.

4. Positive discipline strategies

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Chapter summary

In this part we are talking about Positive Discipline. We are discussing questions: What are the basic elements? How is Positive Discipline different from other parenting programs? What is the theoretical foundation? And other issues as well. To encourage a discussion we suggested some questions. We also provided other useful information such as *Helpful Websites, Center for Parent Information and Resources, Videos, Associations and Societies* and more.

1. Glossary/Words to know/Definitions

"Positive Discipline is based on the theories of Alfred Adler and Rudolf Dreikurs who believed that human behavior is motivated by the core need to feel a sense of belonging and significance. Positive Discipline offers parents, teachers, and caregivers the opportunity to learn through an experiential approach about the child"s world so as to better understand thoughts, feelings and decisions children make. Rather than relying on punishment to **motivate children** to do better, **Positive Discipline stresses** the need for kindness and firmness at the same time: adults model firmness by respecting themselves and the needs of the situation and kindness by respecting the needs of the child and themselves. Positive Discipline emphasizes that mistakes are viewed as opportunities for learning and that we learn best in the context of a caring relationship where effort is made to connect before correction.

Key skills taught to parents are: **effective communication techniques, collaborative problem solving skills, focusingon solutions instead of punishment, and focusing on encouragement instead of praise.** Children then exhibit greater **emotional regulation, response flexibility, and receptivity.** "
http://www.pdcrsantacruz.org/wp-content/uploads/2012/11/PD_FAQ.pdf

"Asperger's syndrome: A disorder of uncertain nosological validity, characterized by the same kind of qualitative abnormalities of reciprocal social interaction that typify autism, together with a restricted, stereotyped, repetitive repertoire of interests and activities. The disorder differs from autism primarily in that there is no general delay or retardation in language or in cognitive development. Most individuals are of normal general intelligence but it is common for them to be markedly clumsy; the condition occurs predominantly in boys (in a ratio of about eight boys to one

girl). It seems highly likely that at least some cases represent mild varieties of autism, but it is uncertain whether or not that is so for all. There is a strong tendency for the abnormalities to persist into adolescence and adult life and it seems that they represent individual characteristics that are not greatly affected by environmental influences. Psychotic episodes occasionally occur in early adult life. (ICD-10 classification of mental and behavioural disorders, Clinical descriptions and diagnostic guidelines, WHO, 2010 update)"

"Autism-Spectrum Disorders: The umbrella term 'autism spectrum disorders' (ASDs) covers conditions such as autism, childhood disintegrative disorder and Asperger syndrome. Core symptoms include a variable mixture of impaired capacity for reciprocal socio-communicative interaction and a restricted, stereotyped repetitive repertoire of interests and activities. Individuals with autism spectrum disorders may have decreased general intellectual ability. (Autism spectrum disorders & other developmental disorders, ISBN 978 92 4 150661 8, WHO, 2013) "

"Childhood Autism: A pervasive developmental disorder defined by the presence of abnormal and/or impaired development that is manifest before the age of 3 years, and by the characteristic type of abnormal functioning in all three areas of social interaction, communication, and restricted, repetitive behaviour. The disorder occurs in boys three to four times more often than in girls. (ICD-10 classification of mental and behavioural disorders, Clinical descriptions and diagnostic guidelines, WHO, 2010 update)"
http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/key-terms-and-definitions-in-mental-health#post

"Behavioural disorders: An umbrella term that includes more specific disorders, such as hyperkinetic disorder or attention deficit hyperactivity disorder (ADHD) or other behavioural disorders. Behavioural symptoms of varying levels of severity are very common in the population. Only children and adolescents with a moderate to severe degree of psychological, social, educational or occupational impairment in multiple settings should be diagnosed as having behavioural disorders. For some children with behavioural disorders, the problem persists into adulthood. (mhGAP Intervention Guide, ISBN 978 92 4 154806 9, WHO, 2010)"

"Depression: Depression is a common mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration. It can be long lasting or recurrent, substantially impairing a person's ability to function at work or school, or cope with daily life. At its most severe, depression can lead to suicide. When mild, depression can be treated without medicines but, when moderate or severe, people may need medication and professional talking treatments. Non-specialists can reliably diagnose and treat depression as part of primary health care. Specialist care is needed for a small proportion of people with complicated depression or those who do not respond to first-line treatments. Depression often starts at a young age. It affects women more often than men, and unemployed people are also at high risk. (Depression, Fact sheet nr 369, WHO, October 2012) "

"Developmental disorder: An umbrella term covering disorders such as intellectual disability / mental retardation as well as pervasive developmental disorders including autism. These disorders usually have a childhood onset, impairment or delay in functions related to central nervous system maturation, and a steady course rather than the remissions and relapses that tend to characterize many other mental disorders. Despite a childhood onset, the developmental disorders tend to persist into adulthood. People with developmental disorders are more vulnerable to physical illness and to develop other priority conditions mentioned in the mhGAP-IG and require additional

attention by health-care providers. (mhGAP Intervention Guide, ISBN 978 92 4 154806 9, WHO, 2010) "
http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/key-terms-and-definitions-in-mental-health#post

"Hyperkinetic disorder / attention deficit hyperactivity disorder (ADHD) : The main features are impaired attention and overactivity. Impaired attention shows itself as breaking off from tasks and leaving activities unfinished. The child or adolescent shifts frequently from one activity to another. These deficits in persistence and attention should be diagnosed as a disorder only if they are excessive for the child or adolescent's age and intelligence, and affect their normal functioning and learning. Overactivity implies excessive restlessness, especially in situations requiring relative calm. It may involve the child or adolescent running and jumping around, getting up from a seat when he or she was supposed to remain seated, excessive talkativeness and noisiness, or fidgeting and wriggling. The characteristic behavioural problems should be of early onset (before age 6 years) and long duration (> 6 months), and not limited to only one setting. (mhGAP Intervention Guide, ISBN 978 92 4 154806 9, WHO, 2010)"

"Intellectual Disability: A significantly reduced ability to understand new or complex information and to learn and apply new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning) which started before adulthood, and has a lasting effect on development. Disability depends not only on a child's health conditions or impairments but also and crucially on the extent to which environmental factors support the child's full participation and inclusion in society. The use of the term "intellectual disability" in this Declaration includes children with autism who have intellectual impairments. For the purposes of this Declaration, the term also encompasses children who have been institutionalized because of a perceived disability or family rejection and who acquire developmental delays and psychological problems as a result of their institutionalization. (European Declaration on the Health of Children and Young People with Intellectual Disabilities and their Families, WHO/Europe, 2010)"
http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/key-terms-and-definitions-in-mental-health#post

"Mental disorder prevention: Focuses on reducing risk factors and enhancing protective factors associated with mental ill health with the aim of reducing the risk, incidence, prevalence and reoccurrence of mental disorders. (Policies & Practice for Mental Health in Europe, ISBN 978 92 890 4279 6, WHO/Europe, 2008) "

"Mental Disorders: Mental disorders comprise a broad range of problems, with different symptoms. They are generally characterized, however, by some combination of disturbed thoughts, emotions, behaviour and relationships with others. Examples are depression, anxiety, conduct disorders in children, bipolar disorders and schizophrenia. Many of these disorders can be successfully treated. (The world health report 2001 - Mental Health: New Understanding, New Hope, page 10, ISBN 92 4 156201 3, WHO)"

"Mental Health: Mental health is a state of well-being in which an individual can realize his or her own potential, cope with the normal stresses of life, work productively and make a contribution to the community. (Strengthening mental health promotion, Fact sheet No 220, WHO, 2001) "
http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/key-terms-and-definitions-in-mental-health#post

2. You are not alone

Mental, behavioral, and developmental health of children aged 2 – 8 years

"Parent-reported information from the 2011-12 National Survey of Children's Health showed that 1 out of 7 U.S. children aged 2 to 8 years had a diagnosed mental, behavioral, or developmental disorder (MBDD). Many family, community, and health-care factors were related to the children having MBDDs.Children with the following characteristics were more likely to have a MBDD: Boys, Children age 6 to 8 years, Non-Hispanic white children, Children were more likely to have a MBDD if they were frompoor families (those living at less than 100% of the federal poverty level) andfamilies that spoke English in the home. "

Mental health of children aged 3 – 17 years

"The first mental health report that describes the number of U.S. children aged 3–17 years who have specific mental disorders used data collected from a variety of data sources between the years 2005-2011. Analysis of the data showed the following results:

Children aged 3-17 years were identified as having a current diagnosis of

- Attention-deficit/hyperactivity disorder (ADHD) (6.8%)
- Behavioral or conduct problems (3.5%)
- Anxiety (3.0%)
- Depression (2.1%)
- Autism spectrum disorder (1.1%)
- Tourette syndrome (0.2%) (among children aged 6–17 years)."

https://www.cdc.gov/childrensmentalhealth/data.html

Depression in Europe: facts and figures

- Each year, 25% of the population suffer from depression or anxiety.
- Neuropsychiatric disorders account for 19.5% of the burden of disease in the European Region, and 26% in European Union (EU) countries.
- These disorders account for up to 40% of years lived with disability, with depression as the main cause.
- Up to 50% of chronic sick leaves are due to depression/anxiety.
- About 50% of major depressions are untreated.
- The cost of mood disorders and anxiety in the EU is about €170 billion per year.

http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/news/news/2012/10/depression-in-europe/depression-in-europe-facts-and-figures

Disability-adjusted life-years (DALYs)

"Neuropsychiatric disorders are the third leading cause of disability-adjusted life years (DALYs) in Europe and account for 15.2%, following cardiovascular diseases accounting for 26.6% and malignant neoplasms (cancers) accounting for 15.4%.

All conditions listed above are noncommunicable diseases which comprise 81.3% of the disease burden in the European Region followed by injuries which account for 10.2%.

Three of the top 15 diseases responsible for disability-adjusted life years are mental health disorders:

- Unipolar depressive disorders are the third cause of DALYs (3.8% of all DALYs);
- Alcohol use disorders are the sixth leading cause of DALYs (2.9% of all DALYs);
- Alzheimer's disease and other dementia are the 15th leading cause of DALYs (1.9% of all DALYs)."

Source: Global Health Estimates 2014 Summary Tables: DALY by cause, age and sex, by WHO Region, 2000-2012.

Years lived with disability (YLDs)

"Mental disorders are by far the largest contributor to chronic conditions afflicting the population of Europe. According to the most recent available data (2012), neuropsychiatric disorders rank as the first cause of years lived with disability (YLD) in Europe, accounting for 36.1% of those attributable to all causes.

- Unipolar depressive disorder alone led to 11% of all YLD, making it the leading chronic condition in Europe.
- Alcohol-related disorders rank third in Europe, accounting for 6.4% of all YLD.
- Anxiety disorders rank sixth, accounting for 4% of all YLD.
- Alzheimer's disease and other dementias rank ninth, accounting for 3% of the total.
- Migraines rank 11th with 2.7%, schizophrenia ranks 15th with 1.8% and bipolar disorder ranks 17th with 1.6% of the total. "

Source: Global Health Estimates 2014 Summary Tables: YLD by cause, age and sex, by WHO Region, 2000-2012.

Looking to the Future

"Public health includes mental health. CDC worked with several agencies to summarize and report this information. The goal is now to build on the strengths of these partnering agencies to develop better ways to document how many children have mental disorders, better understand the impacts of mental disorders, inform needs for treatment and intervention strategies, and promote the mental health of children. This report is an important step on the road to recognizing the impact of childhood mental disorders and developing a public health approach to address children's mental health."

What You Can Do

- **Parents:** You know your child best. Talk to your child's health care professional if you have concerns about the way your child behaves at home, at school, or with friends.

• **Youth:** It is just as important to take care of your mental health as it is of your physical health. If you are angry, worried or sad, don't be afraid to talk about your feelings and reach out to a trusted friend or an adult.

• **Health care professionals:** Early diagnosis and appropriate treatment based on updated guidelines is very important. There are resources available to help diagnose and treat children's mental disorders.

• **Teachers/School Administrators:** Early identification is important, so that children can get the help they need. Work with families and health care professionals if you have concerns about the mental health of a child in your school.

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Bitsko, RH, Holbrook, JR, Kaminski, J, Robinson, LR, Ghandour, R, Smith, C, Peacock, G. *Health-care, Family and Community Factors associated with Mental, Behavioral and Developmental Disorders in Early Childhood – United States, 2011-2012*. MMWR. 2016 Mar 11; 65(9);221-226

https://www.cdc.gov/childrensmentalhealth/data.html

3. Theoretical section on the topic of our specific chapter

Parents, Kids, and Discipline

"How can you provide discipline to your child so that he or she can function well at home and in public? Every parent wants their children to be happy, respectful, respected by others, and able to find their place in the world as well-behaved adults. Nobody wants to be accused of raising a spoiled brat. But sometimes it seems that these goals are miles away from your child's current behavior. Read on for barriers to good behavior, effective discipline techniques, and when to get help for dangerous behavior patterns. "

What Is Discipline?

"Discipline is the process of teaching your child what type of behavior is acceptable and what type is not acceptable. In other words, discipline teaches a child to follow rules. Effective discipline uses many different tools, like positive reinforcement, modeling, and a loving and supportive family. Sometimes, punishments are also an effective tool-but that doesn't mean that good discipline is mostly about punishments. It sounds so straightforward, yet every parent becomes frustrated at one time or another with issues surrounding children and discipline."
https://www.webmd.com/parenting/guide/discipline-tactics#1

What Is Positive Discipline?

"*Positive Discipline* (www.positivediscipline.com) is a program designed to teach young people to become responsible, resourceful members of their communities. Based on the best selling "Positive Discipline" books by Jane Nelsen and others, it promotes **self discipline**: doing the right thing when no one is watching, forcing, or bribing. This happens when we **model and teach** our children important social and **life skills** in a manner that is **deeply respectful** and **encouraging** for both children and adults (including parents, teachers, childcare providers, youth workers, etc.) Positive Discipline teaches adults to employ **kindness and firmness** at the same time, and is neither punitive nor permissive."
https://www.positivediscipline.org/page-271873

The Positive Discipline approach provides a model that takes everyday challenges (or misbehaviors) and turns these trying moments into opportunities to teach children the important life skills they'll need to be successful in the long-term. This approach makes discipline encouraging and helpful instead of discouraging and stressful. http://www.readbrightly.com/positive-discipline-tools-for-parents-teachers/

"Positive Discipline is based on years of research on child development and effective parenting. Parenting is extremely complex and thus Positive Discipline draws from a number of areas of evidence to inform the program, such as the fields of attachment, neurobiology, medicine, parental self-efficacy, reflective function, parental mental health, early childhood learning and care, and the impact of physical and emotional punishment on children. The process of Positive Discipline is education, not treatment. It focuses on the mental (cognitive and affective) antecedents of behaviour in both adults and children. Based on Ajzen's (2002) Theory of Planned Behaviour, Positive Disciplinefocuses on reframing parents' attitudes and beliefs about children, the parent-child relationship and parental self-efficacy as key steps in changing behaviour. Research has shown that several factors -approval of physical punishment, parental beliefs about the reasons for children's behaviour, and anger-are key cognitive and affective predictors of physical punishment (Ateah & Durrant, 2007), thus these are key areas of focus in the program. For detailed information, see Durrant et al's (2014) article in the Canadian Journal of Community Mental Health's special edition on Understanding and Preventing Child Maltreatment."
https://www.ahvna.org/tiny_uploads/pdfs/pdep-faq-november-5-2015.pdf

Five Criteria for "Effective Discipline that teaches":

1. Helps children feel a sense of Belonging and Significance.
2. Is kind and firm at the same time (Mutually respectful and encouraging.)
3. Is effective long-term. (Considers what the child is thinking, feeling, learning, and deciding about himself and his world – and what to do in the future to survive or to thrive.)
4. Teaches important social and life skills. (Respect, concern for others, problem solving, and cooperation as well as the skills to contribute to the home, school or larger community.)
5. Invites children to discover how capable they are. (Encourages the constructive use of personal power and autonomy.) "

"The tools and concepts of Positive Discipline include:

Mutual respect. Adults model firmness by respecting themselves and the needs of the situation, and kindness by respecting the needs of the child.

Identifying the belief behind the behavior. Effective discipline recognizes the reasons kids do what they do and works to change those beliefs, rather than merely attempting to change behavior.

Effective communication and problem solving skills.

Discipline that teaches (and is neither permissive nor punitive.)

Focusing on solutions instead of punishment.

Encouragement (instead of praise.) Encouragement notices effort and improvement, not just success, and builds long-term self-esteem and empowerment."

https://www.positivediscipline.org/page-271873

How Is Positive Discipline Different than Traditional Parenting Models?

Basically, there are two schools of thought on human behavior: Behaviorist and Adlerian. The dominant and traditional practice of the last several generations has been Behaviorist, believing people respond to rewards and punishments in their environment. Adlerian theory, on which Positive Discipline is based, believes people seek a sense of belonging connection) and significance (meaning) in their social context within which they can collaborate and explore mutually respectful and effective solutions.

Behaviorists believe that we have the most influence at the moment of response to a specific behavior; I catch you doing 'right' and I reward you, or I catch you doing 'wrong' and I punish you. This approach works really well with pets and show animals. It often invites resistance and rebellion or unhealthy pleasing with children, because the love of the parents feels conditional and requires obedience. Adlerian and Positive Discipline practitioners feel the best way to influence behavior is in an ongoing relationship founded on mutual respect and dignity.

http://www.pdcrsantacruz.org/wp-content/uploads/2012/11/PD_FAQ.pdf

Discipline Techniques

What you choose may depend on the type of inappropriate behavior your child displays, your child's age, your child's temperament, and your parenting style. The American Academy of Pediatrics, the American Association of Child and Adolescent Psychiatry, and the National Mental Health Association recommend these:

Reward good behavior: Acknowledging good behavior is the best way to encourage your child to continue it. In other words, "Catch him being good." Compliment your child when he or she shows the behavior you've been seeking.

Natural consequences: Your child does something wrong, and you let the child experience the result of that behavior. There's no need for you to "lecture." The child can't blame you for what happened. For example, if a child deliberately breaks a toy, he or she no longer has that toy to play with.

Natural consequences can work well when children don't seem to "hear" your warnings about the potential outcome of their behavior. Be sure, however, that any consequence they might experience isn't dangerous.

Logical consequences: This technique is similar to natural consequences but involves describing to your child what the consequences will be for unacceptable behavior. The consequence is directly linked to the behavior. For example, you tell your child that if he or she doesn't pick up his or her toys, then those (these) toys will be removed for a week.

Taking away privileges: Sometimes there isn't a logical or natural consequence for a bad behavior -- or you don't have time to think it through. In this case, the consequence for unacceptable behavior may be taking away a privilege. For example, if a middle schooler doesn't complete his or her homework on time, you may choose to take away television privileges for the evening. This discipline technique works best if the privilege is:

- Related in some way to the behavior
- Something the child values
- Taken away as soon as possible after the inappropriate behavior (especially for young children)

Time outs: Time outs work if you know exactly what the child did wrong or if you need a break from the child's behavior. Be sure you have a time-out location established ahead of time. It should be a quiet, boring place -- probably not the bedroom (where the child can play) or a dangerous place like a bathroom. This discipline technique can work with children when the child is old enough to understand the purpose of a time out -- usually around age 2 and older, with about a minute of time out for each year of age. Time outs often work best with younger kids for whom the separation from the parent is truly seen as a deprivation.

Corporal (physical) punishment, such as spanking, isn't recommended by the American Academy of Pediatrics or mental health associations. Why? Primarily because nonphysical discipline techniques work better with fewer negative consequences. According to the AAP, spanking may:

- Make children more aggressive
- Become more violent and harm a child
- Cause children to think that it is OK (okay) to physically hurt someone you love

Tips for Maintaining Discipline

Guide your discipline techniques to fit well with your child's temperament. The key to effective discipline is to understand who your child is, especially his temperamental style, and use your discipline to help him or her achieve his or her potential given those talents and tendencies. But your goal should not be to turn him or her into someone he or she is not (for example, to turn a boisterous intense child into a mellow laid-back one).

Communicate your discipline plan. Discipline techniques shouldn't come "out of the blue," especially if you're trying something new. To children who are old enough to understand, during a planned discussion (not in the heat of the moment) explain the technique, why you are using it, and what you hope it will accomplish. Older children may be included in choosing which rewards and consequences would be appropriate.

Be respectful of your child. If you show your child respect -- even when disciplining your child -- your child is more likely to respect you, other family members, and other people in his or her life. If you "lose it" or overreact with disrespect, apologize. Behave the way you want your child to behave.

Be consistent. Any technique will fail if you don't follow through or enforce consequences consistently. If you say, for example, that toys will be off limits for a week, then take them away if the offending behavior continues.

Don't break your discipline rules by giving in during public exhibitions of bad behavior, such as a child throwing a tantrum while shopping. If you give in to the child's demands, the tantrums will continue.

Try to keep your goals and your techniques consistent over time. If more than one adult is responsible for the child's discipline, be sure you agree about the approaches you will use.

When it's done, it's done. After the consequence is over or the time has been served, don't ask for apologies or continue to lecture about the behavior. Help your child return to an appropriate activity.

Understand what's appropriate for your child's development. Before disciplining a child, make sure that the child really did understand what you asked him or her to do. Sometimes parents make demands for behavior that is beyond the child's ability to comply. Just like other skills in life, behaviors often need to be "grown into."

Look for the "why" behind behaviors. If you notice a pattern of inappropriate behavior, part of the solution is to look for "whys." For example, perhaps your child is upset about something else, such as a friend moving away. Maybe your child had a bad day at school. Perhaps your child feels stressed about family problems. Maybe he is tired or hungry.

These explanations don't excuse the behavior, but trying to understand why it happens can help you and your child find ways to prevent it from happening again and again.

Know When and Where to Go for Help

Give yourself a break. Even if you have the best discipline techniques and parenting style, there are some days when nothing seems to work. Or perhaps you've had a bad day, too. Developing skills for positive discipline takes a lot of practice and a lot of time. If you feel you have made a mistake, be honest. Apologize to your child and explain how you plan to change your response the next time.

There may be times when you don't know what to do to next. Or you may not know how to change from what you're doing now to something that will be more effective.

Any time you have questions about your child's behavior and discipline, check in with your child's doctor. It may be time to seek help from a mental health professional when you see:

- Ongoing disrespect for all authorities: parents, teachers, and other adults
- Aggressive or destructive behavior
- Signs of depression, such as feeling blue for a long time, having no friends, or threatening suicide
- Your child or other members of the family use drugs or alcohol to deal with stress or other problems in their lives
- Several relationships within the family are difficult

https://www.webmd.com/parenting/guide/discipline-tactics#1
https://www.positive-parenting-ally.com/good-parenting-skills.html

How does Positive Discipline Create an Optimal Social / Emotional Learning Environment in Schools and Classrooms?

Implementing Positive Discipline in the Classroom is a process that involves teachers and students in true dialogue and problem solving on issues that are of real and practical concern to them. When students and teachers work together to solve problems, they learn to appreciate each other, to understand and respect differences, and to develop social interest by helping each other.

By implementing Positive Discipline in the Classroom using class meetings, students look for win/win solutions and move toward developing competency and self worth through esponsibility in making decisions and helping each other. Students run class meetings,gaining facilitation skills and building confidence in their ability to make decisions democratically. Through Positive Discipline in the Classroom, schools can empower young people with courage, confidence, and life skills. It sounds so time consuming! Why don't children just mind? Punishment does work in that it usually stops misbehavior immediately. On a long-term basis however, it usually results in resentment, revenge, rebellion or reduced selfesteem and sneakiness. Jane Nelsen, the author and founder of the Positive Discipline model, suggests we must beware of what works when the long -term results are negative. When excessive control is used, children depend on an „external locus of control." It is the adult"s responsibility to be constantly in charge of children"s behavior. For teachers and parents, this most often looks like punishment and rewards. This can be a constant source of anxiety and exhaustion for parents.

Positive Discipline is an approach that does not include excessive control or excessive permissiveness.

It is different from other discipline methods in that it is not humiliating to children or to adults. "Connection before correction" presents the opportunity to use discipline that teaches in the context of a healthy, loving relationship. Positive Discipline incorporates kindness and firmness at the same time as the foundation for teaching life competencies. It develops an „internal locus of control." It integrates discipline and the development of life skills into the on-going relationship based on mutual respect and dignity.

http://www.pdcrsantacruz.org/wp-content/uploads/2012/11/PD_FAQ.pdf

4. Quizz

Establish Your Role as Parent

Parents run up against barriers when trying to teach good behavior, like children who:

- Are disrespectful and don't listen: "I must have told you a thousand times!"
- Do listen, but defy or deliberately disobey your request for good behavior.

Your responsibility as a parent is to help your child become self-reliant, respectful, and self-controlled. Relatives, schools, churches, therapists, health care professionals, and others can help. But the primary responsibility for discipline rests with parents.The American Mental Health Association describes three styles of parenting.

Which is yours?

An authoritative parent has clear expectations and consequences and is affectionate toward his or her child. The authoritative parent allows for flexibility and collaborative problem solving with the child when dealing with behavioral challenges. This is the most effective form of parenting.

An authoritarian parent has clear expectations and consequences, but shows little affection toward his or her child. The parent may say things like, "because I'm the Mommy, that's why." This is a less effective form of parenting.

A permissive parent shows lots of affection toward his or her child but provides little discipline. This is a less effective form of parenting.

Parenting Style Quiz

(By Lewis Goldberg (Canbridge), Jason Rentfrow (ORI), Daniel Levitin (McGill University) & Ran Zilca (Intrinsic Mobile, LLC)~ 4 min to take).
https://psychcentral.com/quizzes/parenting-style-quiz/

Parenting Style Test

What does it take to be a good parent? Literature on parenting identifies four main styles: Authoritative, Authoritarian, Permissive and Uninvolved. These are based on the extent to which parents are responsive (offer warmth and support) and demanding (level of behavioral control). Research has shown that a failure to balance these two key aspects of parenting can have very harmful effects on children and their future conduct. Children who grow up in households where there is too much or too little of one trait (or even worse, no recognizable presence of either), tend to have difficulty with social adjustment and often show poor academic performance. Furthermore, they are at risk of developing low self-esteem and disciplinary problems, which often filter into more serious conditions when they reach adulthood in the form of depression and anxiety.

This test is designed to identify your parenting style, based on the level of responsiveness and demandingness you provide. It is made up of two types of questions: scenarios and self-assessment. For each scenario, answer according to how you would most likely behave in a similar situation. For the self-assessment questions, indicate the degree to which the given statements apply to you. In order to receive the most accurate results, please answer each question as honestly as possible.
https://www.psychologytoday.com/tests/personality/parenting-style-test
http://english.bayynat.org.lb/Family/Family_PunishmentChildren.htm#.Wp0rcG5-awM

Rewards and Punishments

We propose that neither rewards nor punishments are helpful in teaching our children to become responsible, caring adults. Why do we say this?

• Rewards and punishments are two sides of the same coin: they both aim to **control** behavior instead of focusing on teaching. Rewards and punishments model the use of **power** as a means of solving problems.

• Rewards and punishments are forms of **"doing to"** children instead of **"doing with"** children. They don't invite children to learn from within or teach cooperative problem solving, both necessary skills in today's world.

• Rewards and punishments **distract** children from the real issues. The child becomes more concerned with avoiding the punishment or gaining the reward than noticing the intrinsic value of the appropriate decision or activity itself.

• Rewards and punishments erode our **relationships** with our children. Relationships with our children are our most important tool for influencing our children's development.

Additional Results of Rewards:

• Rewards teach kids to be **self-centered**. They learn to think, "what's in it for me?" instead of doing the activity simply because it is worth doing for its own sake.

• Rewards are **discouraging**. They are conditional on the successful completion of the activity instead of the effort being made.

• Rewards **interfere with self-esteem**. They create dependency upon an outside person for approval rather than a conscientious evaluation by the child of her own efforts.

• Rewards **eventually lose their effectiveness**.

Additional Results of Punishments (and why SOLUTIONS are better):

• Punishment teaches what **not** to do, not what **to** do.

• Punishment often stops misbehavior, but hardly ever motivates children to do better in the future.

• Punishment is designed to make someone **pay** or suffer for his or her mistakes. Solutions are about **learning**.

• Punishments are about the **past**. Solutions are about the **future**.

• Punishment usually creates anger, hurt, mistrust. Solutions can create encouragement, responsibility, character and respect.

Focus on SOLUTIONS instead of rewards or punishments!
Good solutions are Reasonable, Related, Respectful, and Helpful!

Based on handouts from Lois Ingber, L.C.S.W., 2008. Sources: "Positive Discipline" by Jane Nelsenand "Unconditional Parenting" and "Punished by Rewards" by Alfie Kohn

5. Where can you find assistance and ask for special help? Special Education Services

http://www.positivediscipline.co.uk/
www.positivedisciplinetools.com.
http://edis.ifas.ufl.edu/fy1460
https://www.positiveparentingsolutions.com/parenting/how-to-discipline-your-child
http://www.positive-parents.org/p/home.html
http://www.ahaparenting.com/parenting-tools/positive-discipline/positive-discipline

6. Resources for parents

Helpful Websites

Family Voices: Families who have children and youth with special health care needs can benefit from Family Voices.

Center for Parent Information and Resources

https://www.positivediscipline.com/about-positive-discipline

https://www.parentingforbrain.com/what-is-positive-parenting/

http://www.pbs.org/parents/talkingwithkids/positive_discipline_tips.html

https://rhythmsofplay.com/12-positive-discipline-books-for-parents-and-caregivers/

Videos

https://www.parents.com/kids/discipline/what-is-positive-discipline/

Associations and Societies

https://www.positivediscipline.org/

http://www.attachmentparenting.org/forums/

Blogs

http://blog.positivediscipline.com/2011/12/52-positive-discipline-parenting-tools.html

5. Setting limits

Agnès Ros-Morente, Gemma Filella, Judit Teixiné & Cèlia Moreno
Lleida University

Chapter summary

Affection is a key basic necessity. According to the neurologist, Antonio Damasio, of Portuguese origin, human being's reactions and emotions are related to and associated with the body, while feelings, as in the case of affection, are more related to the mind. For this reason, he explains that when someone experiences emotions, it is an individual process, which, unlike affection, is a process of interaction in which two or more people demonstrate such feelings of friendships and love.

It is normal that in certain daily situations, or even in exceptional situations, parents, familiars and related people, tend to overprotect or give affection without any kind of limit. Affection has been considered necessary and vital for the development of any human being (Solorzano y Virgen, 2014).

Many times we tend to give too much affection by not letting children experience things that can happen in life, and therefore, by not letting them confront any problem they may encounter in the future. For this reason, what we are doing is that children believe that they are not able to do things for themselves, thus believing that they will always need an adult next to them in order to do the things they consider they cannot. This is called overprotection, which is rather a negative concept, since we are not helping the kid at all but we are hindering his/her autonomy.

According to Montessori school, overprotection is defined as the eagerness for our kids to avoid any physical or emotional harm no matter how small s/he is. By the fact that their children are not suffering, lots of times parents tend to look for a culprit, just to exclude their children from any responsibility, which may result dangerous for further levels of learning and for their adaptation in the society or community.

For this reason, it is necessary to place some limits on children, because in order for him/her to be able to become in a social, balanced, secure, independent and autonomous, s/he has to undertake discipline, rules and limits throughout his/her life.

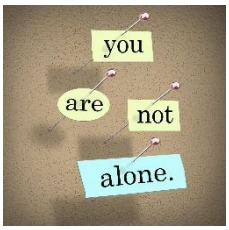
In terms of the types of families, it can be seen that we have the authoritarians, which tend to use rigid patterns. In the second place, the most permissive parents who avoid using authority as a resource. Lastly, the democratic parents, who tend to lead rationally the different activities of the kid.

Finally, it is necessary to say that the next formula has to be always clear: **limits + affection.**

1. Glossary/Words to know/Definitions .

Affection, Limits, Overprotection, Freedom, Discipline, Self-determination, Dependence, Family.

2. You are not alone – Statistics related to children with special needs and their parents



The economic and social transformation that is occurring in the last years is an important factor that affects the care and education of children. This situation also entails a series of uncertainties regarding the role that parents should play with the upbringing of their children. We are involved in long and tiresome working days, as well as being involved in the rapid pace of constant changes (cultural and social) within the society, which affect us directly or indirectly. These are some causes of the crisis values that have affected the activity of fatherhood and motherhood (Filella, 2014).

In this vein, and from a sociologic point of view, Martínez, Sevilla and Bardales (2014) state that overprotection is also an important fact that must be taken into account and that parents are normally not aware of such overprotection during many times. In fact, as it was mentioned previously, the majority of families have to administer the time they spend with their children after long working days and diverse obligations, which may generate feelings of blame and uncertainty, which is even more reflected on families with children with special needs.

It is important to distinguish love and affection (highly necessary for every individual) with overprotection, which can be analysed as a preventive and innate action that isolated the affected individual, and in this case, children. Such isolation is produced in order to avoid problems or obstacles for the kids that are considered in advance from over-protectors (parents). It is relevant to stop associating the protective performances with the learning processes that children have to do on their own. What is normally achieved by foreseeing the events that may come is totally the opposite effect because it can contribute to the development of insecure people that in a future do not know how to confront the daily difficult situations. There is a fine line between care and overprotection and it is difficult to find the balance between them.

Félix (2012) adds another idea about possible situations in which an overprotection on children is generated. Some familial situations, as it was introduced at the beginning, are complex and can entail feelings of blame on parents. This condition can cause somehow that children are neglected and it is at this moment when overprotection emerges, limits and rules are altered and there is an excess of permissiveness. When these factors come together, an inadequate behaviour is acquired for the healthy development of children. Familiars, but especially parents, are the responsible to educate their children, who, in a future, can become and perfume as responsible people. Within the fundamental function, we can find the ones of valuing children, discovering and boosting their capacities, accompanying them in their development and giving them support as well as an unconditional love together with some limits. Most overprotective parents cause that their

children become dependent and not autonomous in the future. In the end, protection hinders the development of the person instead of helping him/her be more mature and accept that in life there are complicated situations that we have to confront in order to keep progressing.

Salorzano ann Virgen (2014) add that overprotection towards people can cause a negative effect and impact because they provide excessive care and, as a result, they do not let their children follow the normal maturity path. Another inconvenient is that it is proved in some inquiries that overprotection is an inappropriate school performance because children are not given the opportunity to develop their own personality, and their learning is constantly limited because they need assistance from people that surround them, who constantly intervene in their personal, emotional, social and educative development.

Overprotection is considered as one of the main factors of vulnerability that go along different emotional difficulties in the adult life. Why? Because in most cases these people live constantly with fear; they have difficulties to establish relationships with others; they are insecure people that need the approval of someone; they fear to confront complex situations because they are under the impression that they are unprotected or they were not given the opportunity to learn how to solve problematic situations in an autonomous way (Páez, Fernández, Campos, Zubieta & Casullo, 2006).

However, it does not exist an immediate or simple solution to administer and control the overprotection of families. It is important to try to be capable of distinguishing care, affection and attention, which are necessary for children, with the overprotective behaviour that respond to feelings related to insecurity.

Differently, what it has certainly been proven to be really important in families is cohesion. Different inquiries (Sotil and Quintana, 2002) have observed that familiar cohesion is of high relevance, since it entails attachment and implicit limits, that is, this cohesion is the result of the degree in which every member of the family has affinity, rapport, they help and give support among the members that form the family structure.

3. Theoretical section on the topic of our specific chapter

Professor Bartolomé Yankovic (2011) describes affection as a process of social interaction between two or more people. Many times affection tends to be related to emotion but they are different concepts, although they are connected. Affection is something that is transferred, whereas emotions are experienced. Affection is a basic and fundamental need. In fact, personal development is incomplete if there is a lack of affective and emotional development.

Freud, in "Group Psychology and the Analysis of the Ego" (1921), indicates that affectivity prevails in the members of a group. A person can feel emotional excitability when s/he feels connected to an idealised group and s/he can even sacrifice his/her personal interests in order to satisfy the collective interests.

Rimé (1989) indicates three levels in affective phenomena:

a) Motivational or basic processes: they are marked by hereditary elements. They make reference to objectives: positive emotions will emerge if there are conditions that facilitate the

achievement of objectives, whereas negative emotions will emerge when there are conditions that hinder the achievement of such objectives.

b) Associative or conditional processes: they represent those emotional reactions that we do not take into consideration at the moment of birth, but they are developing through processes of classic conditioning.

c) Schematic or upper level processes: each and every emotional experience which enhances a cognitive schema that is identified as a representation in the memory of the conditions that took place in any previous episode.

Therefore, we can define affection as a combination of emotions, emotional states, feelings that permeate human acts by coming into play in thoughts, behaviour, the way we establish relationships, enjoy, suffer, etc.

Sometimes we tend to give too much affection, and it results to be rather negative, because then we are not talking about affection but overprotection. What is this concept? What does it entail?

According to an article conducted by Montessori school (2012) overprotection can be defined as the desire to avoid that our kids suffer any emotional or physic damage, no matter how small it is. As it has been commented previously, education is an art, and one of its most difficult challenges is to know to what extent parents can interfere in their child's life, to figure out when they may provide assistance to their child or when parents have to leave their child solve his/her problems on his/her own. It is true that it is difficult to see a child suffering from a complex situation but we have to understand that they have to grow up little by little and they have to achieve their own autonomy. In order for the parents not to see their children suffer, they tend to look for external guilty people, and they do it to leave them with no responsibility; in this way, parents avoid the feeling of failure or suffering from their children.

The same school poses possible effects of overprotection. The clearest one is the **excessive dependence,** since children are young we are used to doing things for them or we are constantly next to them. This dependence creates a huge insecurity in themselves and it is difficult for them to have confidence in themselves. Therefore, bad results or complex situations are not the ones that affect directly their self-esteem but it is the dependence because since they are really young they believe they cannot do anything on their own. For this reason, from such dependence, we are also creating a lack of initiative towards any situation. The child will find difficulties to take the responsibilities from their own acts.

Furthermore, it is possible that overprotection may cause children to become **egocentric and tyrant with their entire environment.** As a consequence of these acts, we tend to see in our society children who may confront their parents violently, with defiant behaviours and infringing the familiar rules and limits. These kids tend to present a high level of egocentrism, together with a low tolerance towards frustration, empathy and self-esteem. Therefore, it is possible that these kids tend to have negative thoughts in the future.

There, we are seeing that overprotection may cause more negative consequences than positive ones. It is clear that children have to be assisted in lots of situations but it is also necessary that they can see they are capable of solving their own problems and that there will not always be an adult next to them to solve such problems for them.

Jares (2006) presents diverse mistakes parents make many times and, among others, we can find the fact of allowing too much freedom without limits, the non-compliance of rules without any

further consequence, overprotection, as well as giving children all the things that they do not have; it is also unfavourable to be too much friendly with children, grant children in order not to be in conflict, show powerlessness, conceal children when they make mistakes or blame teachers when academic results are not the expected or even any conflict that may have happened in the school or high school.

According to Filella (2014), all these mistakes are summed up by saying that the formula **affection + limits** is not put into practice in a good way. In other words, limits are not well used. We cannot avoid our children's problems but we can teach them how to solve them.

Therefore, we can see that affection is important for children but we have to know to what extend in order not to acquire overprotection. Having seen this, we can say that it is necessary to put certain limits. However, what are limits?

Limits and discipline are related concepts. Before defining and emphasising these concepts, it is necessary to know that for any child to become a social, balanced, secure independent and autonomous person must have coped with discipline, rules and limits throughout his/her upbringing. In many occasions, we tend to see these limits or discipline as a punishment or mistreatment towards the child, who is not doing things properly. However, in fact, the word discipline means learning and it constitutes the most adequate means for parents to achieve that their children are able to behave in an adequate way. Discipline is related to correcting any action or attitude that has been done erroneously in a positive way. Putting limits on children helps them take responsibilities from their actions. The most complicated moments is when children grow up and look for their autonomy, for which they tend to go beyond limits and they impose their own desires over their parents' rules. Therefore, it is at this moment when one has to stand firm in the decisions s/he has made, and not letting affection exceed limits, otherwise, coming back to the concept defined previously, we will tend to be overprotective because of the fear to quarrel with them or determine where they can end up (Nava, 2013).

Families play a very important role in this sense, and depending on their performance, behaviour and attitude towards children, and taking into account the interactions that are girded in affection-communication and control-demands dimensions, we can define three family styles: authoritarian, permissive and democratic (López-Soler, Puerto, López-Pina y Prieto, 2009; Baumrind, Larzelere y Owens, 2010).

The authoritarian style is normally expressed as a tendency to use punishment or violence as tools in order to control children's behaviour with pre-established rigid patterns. Whereas parents with permissive style avoid authority, the use of restrictions and punishments providing autonomy as a resource, although this may result in a style in which limits may be lacking. Finally parents with democratic style tend to lead rationally the activities of the child by imposing roles and mature behaviours and using reasoning and negotiation. It is a style that is characterised by bidirectional communication and a shared emphasis between social responsibilities of the actions and development in autonomy and independence on the child (Baumrind, 1996).

Talking about the topic of limits and family styles, there are certain authors that relate it to different genders. It has been proved that mothers tend to show more parenting practices close to the democratic style, while fathers show more parenting practices close to the authoritarian or rigid style (Russel, Hart, Robinson y Olsen, 2003).

As for affection, just as with limits, family play an essential role, and for this reason, we can introduce the concept of family dynamics. Family dynamics can be interpreted as the encounters

between subjectivities, encounters mediated in a series of norms, rules, limits, hierarchy and roles, among others that regulate the living and allows that family life functioning develops harmonically. To do so, it is essential that each family member knows and internalises his/her role within the family unit, which facilitates, to a great extent, his/her adaptation in the internal dynamics of the group (Palacios & Sánchez, 1996).

Family dynamics is characterised because it implies a series of intrinsic characteristics:

- **Communication:** it is the crucial point because familiar relationships are passed through the exchange of thoughts, emotions and feelings among people related to the family group, and which are extrapolated through actions and/or verbal or nonverbal language. Arés (1990) claims that within the family, it is necessary that communication is passed through with clarity with relation to limits, hierarchies, roles and living spaces, because if this is confusing, the communication link and family interaction can be affected because of misunderstandings between the members of the group. This may generate a breakdown of the affective-communicative bond and a lack of family cohesion.
- **Affection:** affection is essential in order to understand the dynamics of the family. Browlby (1990) claims that affective exchange is one of the most important interaction between humans, since feeling to be loved, respected and recognised fosters the personal satisfaction and the intrinsic human development of the family group. According to Richardson (1993) children's behaviours are permeated by limits, labelled by parents and the expectations of children's behaviours in different environments, as well as "by the co-habitation rules, habits, values and the constant affective exchanges".
- **Authority:** in sociology, authority "means the ability one has to orient and determine others' behaviours (Medina, Comellas, Chico et al, 1990). Whereas "the others' care is the gift of authority" (Sennett, 1982). From this point of view, it can be deduced that the exercise of authority is related to the functions of protection and care from parents towards their children.
- **Roles:** within the family there are relationships constructed through love, aversion, discontent, disagreement, agreement, bonds, aspects that adjust a framing of asymmetric and interactive roles that are accepted and experienced in different way from each member of the family circle.

Finally, characteristics of the family dynamics can be summarised in family environment, since it makes reference to the environment generated between the participants of the group and the extent of cohesion, depending on how roles, authority, affection and communication are accepted and experienced. If rules and norms are accomplished, affection will be harmonious; otherwise, hostility will appear by generating levels of stress and nonconformity in the members of the group, which will cause high levels of detachment and indifference within the family.

The socialisation of childhood is produced through parenting practices, which are understood as the way in which parents orient their child's development and they transmit a compilation of values and norms that facilitate the child's incorporation in the social group. In other words, parenting practices are actions carried out by parents and responsible people who take care of the child in order to give a normal response to his/her necessities (Myres, 1994).

Torío, Peña & Caro (2008) found that parents who had children between five and eight years old do not have an established parenting style; sometimes they are democratic, and some others they are authoritarian, which must be considered in order to modify or improve the educational practices existent within the family.

Henao, Ramírez & Ramírez (2007) pose the importance of the family in the socialisation and development during the childhood. A combination of customs and habits of parenting practices, awareness of the necessities of their child, the acceptation of his/her personality; the affection that is expressed and control mechanisms are the bases to regulate their children's behaviour.

Regarding the authoritarian parenting styles, Muslow (2008) proposes that the family is an agent that affects the socio-emotional aspects when offering models that are compatible with the vital reality, and giving opportunities to develop emotionally. Authoritarian and punitive styles generate an emotional dysfunctional development and it is deficient in strategies and emotional competences for the adaptation of diverse contexts that may appear throughout our life. According to Rodríguez (2007), the family is the first context for the transmission of norms, values and behavioural models; and it is the family the one that socialises the child allowing him/her to interiorise basic elements of culture and develop the bases of his/her personality; each family accepts the parenting patterns depending on their characteristics, dynamics and contextual factors, as well as resources and support, among others.

The family and the adequate parenting patterns facilitate the development of social skills and prosocial behaviours during childhood, so it is important to provide sensitivity and orientation. Mestre et al. (1999) highlight that the type of norms that a family establishes, the resources and procedures they use in order to make such norms be accomplished, together with a degree of affection, communication and support between parents and children are fundamental for their personal development, internalisation of values, social skills and the decision-making to solve their problems.

Families with democratic or assertive styles promote an adequate socio-affective development. In Richard de Minzi's inquiries (2005), he found that democratic families promote protective and adaptive coping strategies towards depression, loneliness, while authoritarian families generate insecurities, avoidance of problems, non-adaptive coping strategies, depression, and moreover, loneliness is associated with rejection and selflessness from parents.

Ramírez (2002) poses that parenting practices that parents use are related to children's behavioural problems; like inadequate parenting practices: negative affection, no physical punishment, authoritarian control, emphasis on achievements; these children have higher probabilities to present problems. Precisely, negative affection envisages aggressive behaviour and attention and behavioural problems. Authoritarian control envisages anxiety and depression.

If we transfer these concepts on families that have children with educational special needs, we can see that, generally, it is more difficult to put limits and overprotecting the child is the thing that parents tend to do. A constant preoccupation of families is to ensure a future of wellbeing to their children with disabilities and prepare them to confront upcoming challenges; and ultimately, to prepare them for being self-determined people. The uncertainty that future generates can cause feelings of isolation, loss of confidence and decrease of parents' self-esteem, thus putting in danger their children's welfare, their living standards, and their self-determination purposes (Peralta, 2010).

If we understand self-determination as the combination of skills that allows one to take control of his own in his/her own life and is able to conduct it according to his/her objectives, interests and capacities, it is crucial that parents are prepared and reflect upon promoting their own self-determination through training plans centred on the family. Only then they will be able to help their children acquire knowledge, skills and competences that allow them to be more self-determined. This combination of abilities, moreover, composes one of the dimensions of individual

living standards according to Schalock's model (2004), and therefore, it has major implication in the achievement of the family living standards.

It is important that families with children with disabilities, being realists, know what areas, decisions, actions or tasks should be under their control and which ones should be beyond their competences. Some studies warn that parents are used to leaving little room to foster the autonomy of their children with disabilities (Zulueta & Peralta, 2008). This is partly because they provide environments that are much structured and they show an interaction style that is excessively didactic, directive and intrusive, which does not favour the development of the self-determined behaviour (Grigal, Neubert, Moon y Graham, 2003). Some families underestimate the abilities of their children and they tend to be overprotective on their children. Whereas other families overestimate the capacities of their children and they overwhelm them with tasks that are beyond their possibilities (Peralta, 2008). Both extremes result being dysfunctional for the development of the self-determined behaviour of the person with disability.

Therefore, a family environment that fosters self-determination should be characterised by the establishment of norms, clear limits, and at the same time, by the existence of certain flexibility to adapt to the changes. Furthermore, with their own actions, parents act as models and vital support for their children: there is no more significant relationship than the one established between parents and children (Martínez, Inglés, Piqueras y Ramos, 2010).

In order to increase the abilities and knowledge of parents when having a child, Davis and Wehmeyer (1991) suggest a series of guidelines or strategies that highlight the strengths and positive qualities and that could be useful when structuring an intervention proposal in the family area to support self-determination of children with disabilities:

- To achieve a balance between necessary independence and sufficient protection. Children have to have the opportunity to explore their own world. While there are explicit and obvious limits, parents must "let them go" and this may result difficult many times. For this reason, it is essential that parents allow their children with disabilities to do what they are capable of by their own, taking risks, making mistakes, failing and learning from their failures. Ultimately, they have to let them experience the "dignity of risk" and give them the chance to live such risk (Greenen, Powers, Hogansen, Pittman, 2007). When somebody is denied to participate in significant experiences for him/her, with the risks that it may imply, s/he is also denied to have a meaningful life.
- To make children understand that what they say or do is important and it can be important for others. Parents can encourage their children to ask questions and express their opinions. Participation in discussions and family decisions are a good opportunity to practise it.
- To make children understand that they are important and that it is worth it to spend time with them. It is essential that children participate in the activities and family decisions in order for them to feel valuable and make that their self-confidence increase. Shared stories between parents and children help promote positive relationships, which are essential for self-determination (Wehmeyer y Field, 2007).
- To deal with questions that children may have related to their disability. What is really important is that parents highlight the fact that everyone is a unique being with his/her own individual patterns and strengths, as well as limitations, which can be modified and one can learn to accept them.
- To assess children's goals and purposes without only centring on the results or performances. In order to do so, parents can facilitate self-control development through positive

guidelines; that is to say, they can model behaviours that imply organisation and goals approach. It is good that parents reinforce each step and every effort that their children may do in order to come near the final goal.

- To favour social interactions with other children and different contexts. In this way, opportunities are created to develop communication, interaction, negotiation and self-defence skills.
- To trust children's strengths and have realist but ambitious expectations. Parents can facilitate the learning of their kids by playing an active role: giving them support and affection, together with comforting their fears or mistakes and thus avoiding activities that only lead them to frustration.
- To provide children with opportunities for them to take responsibilities of their own actions, successes and failures. As educators, parents have to put clear limits and justify them. When reasons are given for requests facilitate that children give such reasons for proposals and activities.
- To plan opportunities to make choices. Any event is good for children to express their preferences, make their choices and these have to be respected by others.
- To give positive and honest feedback to make children see that everyone, including parents, can make mistakes but that these can be amended. It is important to make them understand that there is nobody who does everything wrong or right and it is always possible to look for alternative tasks, objectives or goals that are affordable for one's chances (Szymanski, 2000). Negative results in certain tasks or activities must not be translated into personal failures.

When parents have perception of control, they reflect upon their beliefs in disability and perceive self-determination as an educative goal that can be reached and it is desired. When this happens, they are ready to give support and accompany their children, without replacing them, to the challenge of living life by their own (Peralta, 2010).

In this way, given the importance of affection within families and in all community in general, it must be highlighted that this affection has to be accompanied with some limits in order to favour, improve and assure the positive development of any individual. Rules, norms and limits are part of our society, therefore, it is essential children are taught to respect these rules, norms and limits for them to contribute to the wellbeing and the co-habitation of society. If we think about it, in all areas and contexts, there are some limits established with the purpose of co-habiting harmoniously between all the people that live and move in such context, and it is for this reason that children and adolescents need to be taught that such limits exist.

As it has been explained previously, showing affection and acting affectionately is essential. It is very important, however, to take into consideration the importance that setting limits has, since it is not something negative, but on the contrary, it is something that benefits us in the long-term.

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4. Where can you find assistance and ask for special help? Special Education Services

Nowadays, in the Spanish State there is no specific service to help parents in bond and limits areas; however, there are two ways in which families can be helped to carry out this process in an easier way.

One of them is in Pre-school, Infantile and Primary Education schools and high schools. Within the legal framework, together with LOMCE (Organic Law on the Improvement of the Quality of Education, 2013), educational centres are obliged to organise minimum a tutorial throughout the school year with the families of the students. In order to share opinions and talk about the comprehensive development of the student in particular, it is in these sessions where topics related to co-habitation and home education can appear, and where both systems – teacher and family – can go in the same direction.

Secondly, we can find specific centres (see Chapter 3), which addressed for children with special educational needs (NEE), where they can also deal with aspects of children's comprehensive development.

5. Resources for parents

Officially, nowadays, there are no available resources for families with children with special educational needs. As it is logical, if there are no tools or supports at disposal for the families, it entails there is not an adequate offer for the needs of these collectives of people; however, it is necessary to give a response to such situation.

The previous arguments serve as a basis for the project, to be able to analyse accurately the situation and to work on it to modify it, to provide useful resources and tools for families with children with special educational needs.

6. Helping the child problem-solve

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Chapter summary

Self-esteem and self-knowledge are fundamental aspects for people. It is important to create our 'inner selves' by being aware of one's strengths and limitations. In addition, it is interesting to exploit the strengths to strengthen those aspects in which effort is required.

In this way, self-esteem is influenced by different factors, such as expectations, which can be either our own or the ones that people from our surrounding have in us.

Self-esteem and the way the person solves conflicts assertively are attached. A good level of self-esteem together with good emotional and social skills leads to the adequate resolution of conflicts and difficulties that may emerge on a daily basis.

It is inevitable that conflicts emerge, since the interaction with other people implies that, at some stage, there may be a situation in which two or more people do not reach an agreement. In this chapter, conflicts are explained, why they emerge and how we should cope with them to solve them correctly.

Another important concept related to self-esteem is the autonomy, especially in children. The autonomy is a fundamental aspect in the development of people and therefore it must be exploited from the early ages.

1. Glossary/Words to know/Definitions

Self-esteem, Self-concept, Conflict resolution, Autonomy, Special Educational Needs, Confidence, Emotional Education Programmes, Emotions, Basic skills.

2. You are not alone – Statistics related to children with special needs and their parents

In some inquiries carried out with children and teenagers, there is certain relationship among the following factors: positive self-esteem, cooperation, social skills, happiness, tolerance to stress, flexibility, adaptation to changes, social integration, ability to work in groups, consistency, etc. (Garaigordobil & Durá, 2006).

On the contrary, weak self-esteem, or any of its dimensions, has been associated with symptoms of depression, sadness, impulsivity, jealousy, emotional imbalance, risky behavours (Musitu, Jiménez and Murgui, 2007), as well as exaggerated self-esteem leads to aggressive and violent behaviours (Cava, Musitu and Murgui, 2006).

These results indicate that self-esteem can work as a resource that promotes health and protects dysfunction, by emerging as a possible factor of resilience. In this vein, Kobasa (1985)

mentions resilience between the inherent characteristics of resistent personalities and Grotberg (2006) positions resilience as an important element within the resilient factor "inner strength" or "I am".

There is a complex relationship between special education and self-concept. The study that Green and Kariuki (1996) carried out explains that some contradictory issues in the results of investigations about self-concept of children who had difficulties of learning and educational modality. The approach suggests that differences in the self-concept are independent to the type of education received (special, ordinary or mixed) and that they would be dependent on the support given by the teacher and the atmosphere s/he generates in the class. Therefore, we can say that the school atmosphere teachers create depending on the special needs of students, regardless if it is an ordinary or special class, has an impact on the self-concept.

3. **Theoretical section on the topic of our specific chapter**

As it has been mentioned previously, in this part of the chapter three blocks are going to be dealt with: self-esteem, autonomy and resolution of conflicts.

Self-concept and self-esteem

It is important to understand the differences between self-concept and self-esteem. It is safe to say that these two concepts go together because if they are not developed, it is difficult for any of them to grow positively.

In general, it can be said that **self-concept** refers to the view one has of him/herself, that is, s/he sees his/her own limitations but also his/her skills, his/her likes and dislikes, among others. By contrast, **self-esteem** is the assessment about a person's own perception. Such rating is influenced by many factors that stem from the environment in which the person finds; an example would be the expectations the family, peer group, teachers have as well as the vision people have on you, among others.

Bisquerra (2000) defines these two concepts in the following way. Self-esteem is an emotional dimension and self-concept is a cognitive dimension. Therefore, self-esteem is the application of value judgement to self-concept.

Following these ideas, it is interesting to start developing the definition of self-concept.

Self-concept can be defined as the descriptive image or perception one has of his own; like a reflective judgement about one's own capacities, values, preferences or appearances (González-Pienda, Pérez, Glez.-Pumariega y García García, 1997), and therefore, it is considered as a predominant cognitive process (Garaigordobil y Durá, 2006). By contrast, self-esteem is the perception – which has a strong affective connotation – that the person related to the description of his/her own characteristics (Ramírez Peradotto, Duarte Vargas y Muñoz Valdivia, 2005).

The healthy development of self-concept and self-esteem are essential to achieve welfare and mental health of a person. It is fundamental that in interpersonal, familial and school relationships, they child can see himself reflected in a mirror, in which s/he can see a positive image of him/herself, which also means a realist image.

Sureda García (2001) presents action guidelines to improve self-concept that are considered to be applicable to children with and without special education needs and that can guide the work of

families and teachers on a daily basis. This author suggests that, among other strategies, it is essential to support the child in public when s/he has done a good job, ask him/her to do things that s/he can do well, rate an achievement – no matter how small it is –, cheer the students in his/her improvements, giving him/her positive comments, avoid negative situations, not to ridicule him/her in front of his friends, de-dramatize failures and offer alternatives, show him trust, among others.

Bermúdez (1997) proposes a series of strategies for parents: assessing objectively their child, without taking into consideration their expectations – how they want their child to be or how they would like their child to be – and without comparing the child's effort to the others, listen to him actively; talking to the child with descriptive terms about behaviours, without judging any of them and praising the good manners.

In terms of school context, children with special educational needs have to face social situations of different nature. Despite the undeniable benefits the educational integration policies produce, it has to be recognised that the acceptance from teachers and peers is not given in a natural way (Scheepstra, Nakken, y Pjil, 1999). In the academic context, if there are no curricular adaptations when needed, there are two possibilities that may affect their self-concept. First, they may find tasks that they cannot carry out properly because they go beyond their possibilities, and, as a consequence, they will be frustrated. Secondly, the expectations people have on them about the fact that they do not have the same conditions when learning and doing certain things. Therefore, this does not allow their potential to be completely developed.

Having stated this, self-concept has been broadly developed and now self-esteem can be analysed in depth.

According to Argyle (1972), self-esteem is the measurement in which a person approves and accepts him/herself, and considers him/herself as a person to be praised, either totally or in comparison to others. Complementing this definition, Bisquerra (2000) explains that self-esteem as one of those positive feelings towards oneself and the confidence in the own skills and abilities to face the challenges that may emerge.

Branden (1989) distinguishes two components within self-esteem: a feeling of personal capacities and a feeling of self-worth. In other words, self-esteem is the sum of confidence and respect for oneself. It reflects the implicit judgement that one has of his/her own capacities to confront life challenges (understand and overcome problems) and their right to be happy (respect and defend one's interests and needs).

Self-esteem is generated through personal experiences that are contrasted with experiences from reality and the attitudes with which the others show towards that person in particular. The determinants of self-esteem are experiences, expectations and attributions. It is relevant to put emphasis on the difference between experience and expectation.

Experiences refer to all those situations that a person lives and provide him/her information of him/herself (school experiences play an important role in this self-knowledge); whereas expectations are understood as all those things that people expect from the subject in particular (Argyle, 1972).

In this vein, it can be said that self-esteem comprises value and affective components of self-concept (Cardenal and Fierro, 2004); it is an emotional response that is experiences when contemplating and evaluating different aspects of oneself (Heatherton and Wyland, 2003). It has to be taken into account that self-concept is relatively stable, although it can also change, and therefore, it can happen that self-esteem also changes in order to be adapted to the new image of the inner self.

It is considered that a high self-esteem is an essential factor for the social and emotional adjustment so that when self-esteem is low some distortions can be produced in the cognitive process of the decision-making (Bisquerra, 1991).

Happiness is another factor to bear in mind since it facilitates empathy and favours the appearance of altruist behaviours, social compromise and volunteer work. It generates positive attitudes towards oneself and others, which favours self-esteem, self-confidence, good social relationships, cognitive performance, resolution of problems, creativity, learning, memorisation, curiosity, mental flexibility and other positive aspects of the human behaviour (Bisquerra, 2000).

According to Bisquerra (2000) a person with a healthy self-esteem is *independent from the context*. For an ordinary person, with low self-esteem, valuing him/herself depends on the context. S/he worries excessively how the others might see him/her. S/he needs a certain degree of acceptance to feel good. If s/he received criticism, his/her self-esteem is affected. His/her mood depends on how the others perceive him/her. A person with a healthy self-esteem is neither presumptuous nor arrogant.

The beliefs a person has from the context that surrounds him/her involve both cognitive and affective aspects, which leads us to think that the genesis and development of self-concept and self-esteem are complementary and continuous processes throughout the development cycle of a person (González Arratia and Gil Lacruz, 2006).

Developing self-esteem implies the development of the belief that one is competent to live and deserves to be happy, and therefore, s/he has to confront life with a higher confidence, benevolence and optimism, which helps him/her achieve goals and experience plenitude. Developing self-esteem is to broaden our capacity to be happy (Branden, 1989).

Self-esteem can be considered both a global and multidimensional construct. In the global viewpoint, it refers to the generalised quality that permeates all vital aspects of the individual; while in the multidimensional viewpoint, self-esteem refers to the performance, social self-esteem and physic self-esteem (Heathertorn and Wyland, 2003), in feelings of personal capacity and feelings of self-worth or in another variety of dimensions; depending on the theoretical scope adopted and the cultural context in which concepts, measurements and models are developed.

According to Hewitt (2005), self-esteem is an emotion socially constructed, and therefore, it is influenced by the cultural context. From Hewitt's perspective, self-esteem is an emotion that can be handled and auto-regulated depending on the social circumstances that take place, as it would happen with other emotions like joy, anger or fear.

The relationship between parents and children plays an important role with self-esteem. It can be said that "what parents feel, think and do for their children and the way they communicate it has an impact on what children perceive themselves" (Barudy and Dantangnan, 2005). Parents reflect how they feel in the presence of a child and this is interiorised by the child, who keeps updating and reinforcing himself in each new experience. The adequate parenthood is often characterised, therefore, by the facilitation of the development of a healthy identity and a high self-esteem. On the contrary, parents who do not possess such capacities send negative messages to their children, which subsequently explains a negative self-concept and a low self-esteem.

Therefore, it is of paramount importance to take action and try to exploit and develop both the self-concept and self-esteem in children from early ages, and in this way, by making them know how to live and live together in the current society.

Autonomy in children

Soto (2009) defines personal autonomy as the capacity to be oneself in daily activities. Basic activities related to the personal care of oneself (getting dressed, grooming, eating…), the physical functioning (walking, moving in the house, etc) and mental functioning, which is used in a daily way and is essential for the person to live in an autonomous way and to adapt in the environment. Autonomy and independence are not only the capacity to do things for one's own but also the knowledge to recognise to whom we can ask for help.

Matito (2004), in order to refer to development skills, uses the term 'basic personal and social development skills' and defines this term as "the combination of essential skills or abilities that allow establishing and/or foster physical, conceptual, emotional and practical capacities in each person, aiming at achieving sufficient autonomy and socialisation for their existence".

Family is the first social subsystem where roles can be observed and practised, by offering models in a safe context. The family is where we start to live together, to communicate better, to respect the others and to rate important things. Socialisation and personal autonomy go together in the evolutionary development of the human being. The family will have to provide enough opportunities to develop those personal and social abilities and competences that allow children to grow with confidence and autonomy, being able to interact and perform satisfactorily in the social area. In the case of a child with special needs, it is frequent to see the concern and wish of the parents to see how their child grows up and becomes an independent adult. In most of situations, the level of autonomy that the child with disability can reach will depend on the attitudes and behaviours that parents have towards the child. It is important that parents leave a degree of freedom and independence to the child, who should be able to make his/her own decisions and who should have certain responsibilities and liabilities like any other member of the family (Gafo and Pérez, 2001).

The most important problem for children when they aim to develop and achieve a certain level of autonomy is the overprotection that people with disabilities generally undergo, the lack of opportunities to be able to work, the personal and social abilities of autonomy in real situations that hinder these people to achieve their right of independence. However, nowadays, thanks to the job of professionals who advocate for a full and worthy life for people with special education needs, exits to achieve independence are somewhat bigger, without the necessity to go to a residence or supervised flats but these people can be in a normalised environment, live independently with the necessary supports, but with a totally different methodology, such as sharing a flat with other students. Some of these projects are already undertaken and offer another real and effective exit to these young people, since they can be independent and live on their own with the necessary aids and resources, if these are provided (Soto, 2009).

To conclude this section, it is interesting to reflect on the idea that both the family and the school are responsible that children know how to live and live together in the world they have to live through. So it is of vital importance that these two pillars (family and school) are responsible for the future of citizens, who have to know how to overcome daily difficulties, acquire a personality that allow them to act with freedom, responsibility, autonomy and be self-critical with their behaviour and actions.

Resolution of conflicts

As it has been mentioned previously, cohabitation necessarily involves the appearance of conflicts. Conflicts have to be solved properly and in an assertive way to be able to bring

cohabitation back and to bring personal and social welfare. Autonomy is important for the resolution of conflicts given the fact that that the ideal thing would be to confront conflicts in an autonomous way, that is, being able to solve problems and conflicts that emerge on one's own. This idea does not imply that one cannot ask for help, seek solutions with people that surround you or share the problem. Nonetheless, families and teachers teams have to provide tools to be able to solve little problems in an autonomous way that may emerge on a daily basis.

A conflict emerges when two or more people are in disagreement due to a mismatch of values, interests or needs. The emotions we feel at that moment in particular are important and it is of paramount importance that we know how to handle them.

Neuroscience, with its recent investigations, has proven that emotions play an important role in the daily lives of people, since they come into play when we make decisions, about our way to act and to solve different conflicts that may appear throughout our lives as well. It is also proven that most of times we do not resolve conflicts properly due to the bad management of emotions, therefore, teaching children to solve conflicts satisfactorily can strengthen their personal development. Conflicts that are badly handled tend to increase severity (Caballo, Arias, Caldero, Salazar, and Irurtia, 2011; Cerezo, 2006; Martorell, González, Rasal and Estellés, 2009; Pérez, Gázquez, Mercader, Molero and García, 2011).

The resolution of conflicts can be constructive, that is, the fact of having confronted a conflict and solve it can help to grow up and mature as a person; one can learn from the situation in order not to repeat it or if it is repeated, we can act in a better way. The resolution can also be destructive, and therefore it can have the opposite effect, everything depends on the way the solution of the conflict is conducted. Depending on the resolution of the conflict, the relationship between people can be altered, and for this reason, all conflictive situations that emerge with other people require a good emotional management. Consequently, from a bit more than a decade some emotional educational programmes are being incorporated in schools both in national (Bisquerra, Soldevila, Ribes, Filella and Agulló, 2005; Güell and Muñoz, 2003; López-Cassà, 2003; Monjas 1999; Pascual and Cuadrado, 2001; Renom, 2003; Vallés and Vallès, 2000) level and international level (Olweus, 2001; Espelage and Swearer, 2004; Juvonen and Graham; 2001).

The key conditions to be able to have a fulfilling life are the basic abilities of social and personal development. However, it is necessary to highlight that people with special needs, these abilities are even more important, especially personal autonomy, since it allows them to have a more independent life. From childhood, through adolescence and towards adulthood, we incorporate knowledge and develop abilities to face effectively the contexts we go through (Soto, 2009).

In conclusion, all concepts dealt with in this chapter are blended, some need the development of the others to be able to reach their full potential. It is relevant to understand that these are not external factors to the person but they are personal aspects that must be developed for the person to have personal welfare, to create a positive self-concept, and therefore, a good autonomy in order to confront daily challenges on one's own.

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4. Where can you find assistance and ask for special help? Special Education Services

Currently, in the Spanish State there is no specific service to help parents foster the development of self-concept, self-esteem and autonomy; however, there are two ways in which families can receive aids to carry out this process in a more easily way.

In terms of education, and more precisely in Pre-school educational centres, Infantile education, Primary education and Secondary Education, regulated by LOMCE (Organic Law on Education Improvement) must foster self-concept, self-esteem and autonomy throughout the stay of students in such centres. Dealing with these concepts in a specific way or in an indirect way, it should not only be present in a subject but these phenomena should be dealt with in a cross-curricular way, that is, in all subjects that the child attends.

More specifically, and therefore making reference to the area of Catalonia, thanks to the competences of the educational department of Generalitat (institutional system that politically organises the self-government of Catalonia), specific curriculums have been designed for each age, and within them it is stated that it is compulsory to provide tools and resources to develop the following concepts:

- **Infantile Education:** *Decree 181/2008, September 9th, establishes the organisation of teaching programmes in second cycle of infantile education.* Self-concept, autonomy and self-esteem have to be dealt with.
- **Primary Education:** *Decree 119/2015, June 23rd, establishes the organisation of teaching programmes in the procedure, documents and formal requirement of the process of evaluation in primary education.* Self-concept, autonomy, self-esteem and resolution of conflicts have to be dealt with.
- **Secondary Education:** *Decree 187/2015, August 25th, establishes the organisation of teaching programmes of the compulsory secondary education.* Self-concept, autonomy, self-esteem and resolution of conflicts have to be dealt with.

Additionally, we can find specific centres (see Chapter 3), addressed at children with special educational needs (NEE), where these aspects of comprehensive development of children can be dealt with, not as the main purpose but they can be dealt with in an indirect way for their development.

5. Resources for parents

At an official level, there are no available resources for families with children with special educational needs. Logically, having no availability of tools and supports for families entails that there are no adequate offers for the needs of this collectives, although it is necessary to give a response to

this situation.

The previous reasons serve as the basis of the project to be able to analyse accurately the situation and work on it to modify it, provide useful resources and tools for families with children with special educational needs.

Part III

Parenting children with special needs

1. Parenting children with intellectual disabilities

Having a Child with Intellectual Disabilities (ID)

Natalija Lisak
University of Zagreb

Dear parent,

First of all, we would like to emphasize that all parents expect and plan for a healthy and lively child and a very small number of them think of that their child may have difficulties. So, you can never be ready for this!

Please, feel welcome in the beginning of this chapter and pleasant during the whole process of reading it.

We do accept you as a „*normal parent* „with all issues that parenting has and we do hope so that you fill find out something important for your parental role, personal and family life.

What are intellectual disabilities?

„Intellectual disability is a disability characterized by **significant limitations both in intellectual functioning** (reasoning, learning, problem solving) **and in adaptive behaviour**, which covers a range of everyday social and practical skills. This disability originates before the age of 18“ (AAIDD, 2010)

The terms intellectual disability and adaptive behavior

Intellectual function refers to intelligence which means general mental ability. In general mental ability we do include following determinants: opinion, inference, reasoning, planning, problem solving, an abstract opinion, understanding complex ideas, learning speed, learning through experience (AAIDD, 2010). Significant limitations of intellectual functioning means to have IQ that is two standard deviations bellow the mean intelligence (lower then 70). In accordance to ICD-10 - International Statistical Classification of Diseases and Related Health Problems 10th Revision (WHO, 2016) it could be distinguished four categories of persons with intellectual disabilities: people with mild intellectual disabilities, IQ = 50-70, developmental age of the child is from 7 to 12 years; moderate intellectual difficulties, IQ = 35-49, developmental age child is from 4 up to 7 years; severe intellectual difficulties, IQ = 20-34, developmental age of child from 2 up to 4 years; profound or multiple intellectual disabilities IQ below 20, developmental age under 2 years. The levels will be describing under the chapter separately for every level of ID and with specificities of functioning in everyday activities.

When we try to define term adaptive behavior then we could say that it refers to a set of conceptual, social and practical skills that a person has learned for functioning in everyday life (AAIDD, 2010). *Conceptual skills* could be defined as skills like expressive and receptive language, academic skills, writing, reading, the concept of money, self-realization and so on (AAIDD, 2010). *Social skills* represent interpersonal skills such as development of responsibility, trusting in relations; respect the rules in communication and relation, avoiding the role of the victim and so on. Finally, *practical skills* mean ability of person for nutrition, mobility, dressing, hygiene habits, meal preparation, housekeeping, travelling and so on (AAIDD, 2010). Child or adult person with intellectual disability in the field of conceptual skills could have a problem in adaptive skills for example in a way that she/he will learn slower letters and words, will forget some new information because she/he has got a problem with short-term memory or will never go alone to supermarket because she/he has got no idea of the value of money and then she/he will need support. In the field of social skills the child or adult person with ID will need support in establishing relationships and recognizing who has good intentions and who does not or in whom to trust or not and who can be a friend and who does not. In the field of practical skills people with ID could have problem in memory how to dress themselves, how to prepare meal, or how to go outside of the house and use public transport to school safety. Some of them will always need help in some of these activities but also some of them could need a support only in the begging of the activity and then this kind of support in named occasional support (AAIDD, 2010).

Levels of Intellectual Disability

Mild intellectual disability

IQ 50 to 70

- ✓ Slower than typical in all developmental areas
- ✓ No unusual physical characteristics
- ✓ Able to learn practical life skills
- ✓ Attains reading and math skills up to grade levels 3 to 6
- ✓ Able to blend in socially
- ✓ Functions in daily life

(https://www.healthyplace.com/neurodevelopmental-disorders/intellectual-disability/mild-moderate-severe-intellectual-disability-differences/)

Moderate intellectual disability

IQ 35 to 49

- ✓ Noticeable developmental delays (i.e. speech, motor skills)
- ✓ May have physical signs of impairment (i.e. thick tongue)
- ✓ Can communicate in basic, simple ways
- ✓ Able to learn basic health and safety skills
- ✓ Can complete self-care activities
- ✓ Can travel alone to nearby, familiar places

(https://www.healthyplace.com/neurodevelopmental-disorders/intellectual-disability/mild-moderate-severe-intellectual-disability-differences/)

Severe intellectual disability

IQ 20 to 34

- ✓ Considerable delays in development
- ✓ Understands speech, but little ability to communicate
- ✓ Able to learn daily routines
- ✓ May learn very simple self-care
- ✓ Needs direct supervision in social situations

(https://www.healthyplace.com/neurodevelopmental-disorders/intellectual-disability/mild-moderate-severe-intellectual-disability-differences/)

There are certain differences in support for a child with mild intellectual disability of those for child with severe or profound intellectual disability. Child with mild intellectual disability could go to regular primary school with support of teaching assistant and have individual educational plan in learning process. Also, he/she will learn academic knowledge and activities of daily living together with peers. On the secondary school level she/he could finish an occupation for certain profession such as for example assistant chef or auxiliary baker and work on open market for a salary. But if child has got profound intellectual disability then this means that child will need 24 hours daily support from system and family members. For example this person could have complex health needs and need for medications and physical care. Then she/he will need support in feeding and dressing, sometime needs special medical equipment. Also, child could have serious behavior problems such as the impossibility of verbal communication with the environment which is resulting in anger or inappropriate physical reactions. Further, researchers have shown that children with more severe intellectual disability will have additional disabilities (visual impairment, motor problems etc.) more often than children with mild intellectual disabilities (Poppes et al. 2010).

The level of intellectual disability and having the additional disabilities effects on the level of stress in families who have child with ID. The results of the researches of differences in stress levels in parents of children with Down syndrome and parents of children with autism spectrum disorders show that differences in the intensity of stress depending not on the type of difficulty, but depending on the manifestation of the child's difficulty (**http://www.intellectualdisability.info/family/articles/family-issues**). This means that **it appears that factors such as communication difficulties and behavioral problems - rather than particular diagnostic groups predict stress in families. Providing physical care may be less stressful than supporting a person with behavioral problems or complex needs (http://www.intellectualdisability.info/family/articles/family-issues).**

Early Signs and Symptoms of ID

It is known that persons with significant limitations of intellectual functioning could have also difficulties in the development of: speech, perception, memory and emotional development (AAIDD, 2010).

Speech

- ✓ Child could have a problem with expressive and receptive language (seems like he/she couldn't understand or can't tell you some words or letters or voices) and could have poorer vocabulary

Perception

- ✓ Child could have some difficulties in sensory perception and integrations (we have 7 sensory areas form which our brain integrates "a pictures" of world around us)

Memory

- ✓ Child could have some difficulties in cogitation, making conclusion, making decision, reasoning, planning to do something
- ✓ Difficulties in abstract thinking and solving complex ideas

- ✓ Child could learn slowly then his/her peers in all areas of learning and have some problems with learning through experience and generalizing

Emotional development

- ✓ Child could have some difficulties in emotional perception and reactions
- ✓ Could have less empathy with the others and sometimes sees others as objects rather than beings who act and react
- ✓ Child could need more of your attention and he/she really enjoy activities with significant others for example usually parents
- ✓ Child sometimes could want you to him-/herself and could show jealousy to another child

What Causes the ID and what is its Prevalence?

Till now it is known that ID may be the most common caused by:

- ✓ **chromosomal aberrations** or changes on chromosomes (for example Down syndrome, Fragile X, Prader Willi, Angelman Syndrome)
- ✓ **complications in pregnancy and at birth** (premature, lack of oxygen, injury and so on)
- ✓ **bacteria or virus infections** or disease (for example hydrocephalus, meningitis, encephalitis)
- ✓ **chemical factors** (radiation, chemotherapy, corticosteroids)
- ✓ parental **alcohol or drugs consumption**

How many children/people have ID?

- ✓ **the average prevalence rate of ID** in the adult population aged 18 years and over was **15.6%** across 59 countries from the World Health Survey (WHO, 2011)
- ✓ prevalence of ID in **higher income countries** from this study was **11.8%** (WHO, 2011)
- ✓ prevalence of ID in **low income countries** from this study was **18.0%** (WHO,2011)

Child with ID at Home

Your child with ID could have some specificity in every day functioning that could influence the dynamic of your everyday family life and relations. Here are some examples of behaviors and situations in everyday family activities that could be happened**.** Later on in the part of chapter named *Tips for dealing with your child's disability and support* for parent you could find some explanations and suggestions for dealing with this kind of situations.

- child could be too sensitive on tactile stimuli (for example they do not like that you touch their mouth, they could obstruct the lashing, scratching, kneading) –this could influence on the dynamic of family because of feeding, taking care of another child, or visiting hair cater also child could have problems in eye contact and some other visual difficulties (for example strabismus, short sighted or myopic, longsighted or hyperopic)
- child could be sensory too sensitive on sounds, touches, movement, visual stimuli and could then jump, scream or be afraid = these situations could influence your relation to other family members (for example brother/sister could not watch television, father can't use some noisy device or tools, mother can't listening the music)
- your child could have problems with speech and language and also in communication with you and other family members - this could make some frustrations between you and child with ID because you cannot understand the child's needs (use alternative communication for example PECS; read more in Tips for parents)
- your child could have some behavior problems (such as tongue rush, sneezing, spitting, refusing to react, shouting, scratching, destroying) because of which you are staying at home and not going on for example birthday at your friends or relatives.

Child with LD in the School

Children with ID in educational system need different type of support and from different resources such us teachers, profesionals, teaching assistants, paretns and peers. For child with ID in academic sense it is very imprtant to have an appropriate IEP and educational program, as well as professionals support as well as teachers understanding the child difficulties. But also it is very imprtant that schools environment an all imprtant acgtors ineducational system develop also acceptance of child and new social skills through groups activities, and building important relationships with their peers. For parents, it is very important to invest in positive relationships with the adults in child's school, especially the teachers and therapists who will interact with them and track their progress on a regular basis. Parents are suggested to prevent miscommunication by being upfront about child's intellectual disabilities, and also to discuss child's progress on a consistent schedule thorough attending meetings, taking notes, asking questions, and be open to the process of helping child as the member of a support team in educational system (https://www.integrityinc.org/school-tips-children-intellectual-disabilities/).

Some of the most recognized issues and adjustments of children with ID in the school environment and education system, in accordance to the research findings (Buckley & Bird, 2000) are presented here: child could go into regular or special school and it mostly depends on level of intellectual functioning, adaptive behaviour and the type of support child needs**;** will have individual educational plan (sometimes this means that will have special aims in curriculum different form the peers – like special or adopted programme**;** child will need support from the experts and teaching assistant**;** will learn slower then peers and therefore he /she is needed to repeat a certain stimulation several times**;** child could use specific strategies for learning and visual didactic materials (PECS, mental maps) because they are very good in visual memory**;** child could learn through creative workshops to have better memorizing; when reads child could have problems with some letters and voices so they could slowly read and spell when reading**;** child could have problem in writing letter because they need support in development of fine motor skills and this should be practiced more**;** child could have problems in understanding words and sentences and could use electronic device as support in learning.

Child with ID and Peers

We could say that social competence presents cognitive and social adaptive skills so children who have some problems influenced by cognitive, communicative and behavioral problems will consequently have a problem in establishing and maintaining relationships. In accordance to findings most children with developmental disabilities will have problems with attention, higher order processes, work memory, and processing of social information, which will consequently negatively affect their peer competence (Žic Ralić, 2014). Research has also shown that children and adults with intellectual disabilities are less able to recognize emotions based on facial expression, which is one of the essential preconditions for an adequate response in social interaction (Lancioni et al., 2009., in Mihoković, 2016). For example some determinants of social development for children with mild intellectual disabilities will imply dependence on the opinion of others, acceptance of social rules, loyalty towards "important persons" and the desire to belong to the group (Mihoković, 2016). For children with moderate or severe ID determinants are interest for peers, identification with an important person and dependence on an important person, and finally children with profound ID have further determinants of social relations: familiarity with people in the family, little interest in peers, addiction to the emotional state of the educator taking the initiative towards an unpopular environment and lack of interest even for the material environment (Mihoković, 2016). Also researches on self-assessment of children with ID have shown that their image is more similar to that of younger children of typical development and may have a distorted picture of itself (Donohue et al., 2010). When we are talking about the experience of friendship then we could state that the friendship of children with ID is characterized by lower stability and a lower level of empathy. While understanding that with a friend you share private information exists amongst children with ID, a limited number of such topics have been noted with them. It has also been found that children with ID have fewer friends and twice the possibility of belonging to a group of peers of typical developmental children (Sukhodolsky, Butter, 2007. in Mihoković, 2016).

Because of these facts the parents of children with ID could experiences following examples of social interactions:

- ✓ Child could interact less often with peers and he/she would rather play with you or with familiar persons brother/sister
- ✓ Has got his/her own interest in playing and doesn't want to accept ideas of peers and doesn't want or play in a group
- ✓ Could have some conflict situations with peers because he/she would like to play with certain toy and right know which peers don't accept
- ✓ Could have problems in finding a friends because his/her interest are not similar to interest of peers his/her age
- ✓ Could behave inappropriate with peers (for example he/she can't wait on his/her turn)

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3134366/

Tips for Dealing with Your Child's Disability and Support for You

We were trying to find out some suggestions for you so that you could function well in your family dynamic relations and that you could take care of our needs also. We put you some ideas, quotas and references where you could read more about the specific topic.

➢ **How to help you to have easier time in your child's early age**

- ✓ Most parents, in the period of child's early age, are in the process of accepting the difficulties that child has got and in the process of mourning so parents can be vulnerable and need more support than ever
- ✓ Usually at that time of child's early age the service support is not well organized so parents knocking on may doors and visit a lot of specialist
- ✓ Parents learn a lot how to provide support for their child, they support development of motor skills, use alternative communication tools (PECS, certain cognitive strategies for learning for example first letter, nouns and symbols, memory training)
- ✓ You could find some interesting ideas for support your child in the early age on the links below

https://www.down-syndrome.org/en-us/resources/videos/
Practical guidance to support effective early intervention and education for children with Down syndrome from Down Syndrome Education organization
https://www.pinterest.com/mamajoyx9/pecs-and-clip-art-sources-autism-asd-down-syndrome/
Picture Exchange Communication System (PECS) and Clip Art Sources

➢ **How to upbringing your child- here are some tips for positive parenting**

- ✓ Lot of parents have a problem with finding a solution for situation when child for example gas got some behaviour problems or when expresses needs in an inappropriate way or some similar situation.

- ✓ When you would like to do right things on a right way, to support your child and also to have a good parenting skills choose some techniques for practicing positive parenting and supporting the needs of your children

Practice positive parenting techniques
https://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/index.html
https://www.positiveparentingsolutions.com/parenting/start-10-tips-better-behavior
https://www.essentialparent.com/lesson/seven-tips-to-positive-parenting-2329/

➢ Groups support for parents and parents associations

- ✓ Sometimes you need a time for yourself, you need support and understanding.
- ✓ This is your normal and health needs and you should respect it
- ✓ If you are taking care of your needs this could empower you so that you can give quality support to your partner and your child
- ✓ Many parents of children with ID have stated that their children positively impacted their lives by helping them develop empathy, patience, tolerance, sensitivity, and more positive spousal relations. These experiences you could find on link bellow:

(https://www.skepticink.com/gps/2014/12/01/parenting-a-child-with-intellectual-disability/
http://parenttoparentnys.org/support/support-parents/
http://parenttoparentnys.org/training/online-training/
http://www.parentcompanion.org/article/tips-to-start-a-parent-support-group
http://raisingchildren.net.au/looking_after_yourself/looking_after_yourself.html
http://raisingchildren.net.au/articles/backing_each_other_up.html/context/590
http://raisingchildren.net.au/articles/parent_teamwork_skills_-_talking.html/context/590
http://raisingchildren.net.au/articles/parent_teamwork_skills_-_listening.html/context/590

➢ Partner to partner support - experience of parents of children with ID

- ✓ Supportive partner relationship is very important for good family and personal quality of life
- ✓ How you could support your partner and how you could tell your partner what kind of support do you need in your relationship from him/her you could find on links bellow:

http://raisingchildren.net.au/articles/acceptance.html/context/590
http://raisingchildren.net.au/articles/your_relationship_with_your_partner.html
http://raisingchildren.net.au/articles/building_a_good_relationship_with_your_family.html
http://raisingchildren.net.au/articles/building_a_good_relationship_with_your_family.html/context/312
http://raisingchildren.net.au/fathers/fathers.html

- ✓ It is very important for you and your partner to back each other and to respect and accept each other
- ✓ Here are some tips for improving acceptance of your partner and for closing to each other:

Spend time on your relationship

Spend time together on shared interests.
Show your interest by asking about your partner's activities and joining in when invited.
Think of some things you could do to show your partner your love and appreciation.
Think of activities you did together when you first met. Consider what you liked and how you might do those activities together again.
Talk with your partner about happy times you've had together.

Be generous with your understanding

When you're talking and listening with your partner, remember that it can be difficult to explain what you want and how you feel to someone else. Sometimes the words come out wrong!
Encourage your partner to open up by asking open-ended questions and not interrupting.
Look for and acknowledge your partner's positive intentions – for example, 'I know that you're working long hours because you want to take care of us'.
Ask your partner to explain or give more information if you don't understand what's being said.
Listen, without defending your own position or behaviour.
Acknowledge your partner's point of view even if you don't agree. For example, 'I can understand why you're angry that I asked my parents over for the weekend without talking to you first'.
Avoid jumping to conclusions, blaming or criticising your partner.
Give your partner the benefit of the doubt.

Idea for support your child learning process and child's development in preschool and school age

- ✓ When you have child with intellectual disability you often learn how to provide some new methods and techniques to support your child's development and sometime you become like professionals or experts in the field of giving a support for child with ID
- ✓ To some extant this is reasonable because you know the best your child needs but still you are tired with your parent roles and you don't need some more obligations and you want to be a parent to you child not a professional
- ✓ But still today in modern models of support you as a parent you have important role in the process of organizing support for your child.
- ✓ Experts will ask you about the information and they will learn you how to do some methods at home with your child
- ✓ You could find some helpful ideas to support the process of learning and memory with your child as well as support him/her to learn letters and numbers

https://www.down-syndrome.org/en-us/
https://www.down-syndrome.org/en-us/resources/
https://www.seeandlearn.org/en-us/language-and-reading/?_ga=2.5334387.1925064855.1514054026-1946371723.1514054026
Set of handbooks or manuals for support of learning process, memory, reading and writing for children with ID, special created for children with Down syndrome (www.downsed.org)
https://www.skepticink.com/gps/2014/12/01/parenting-a-child-with-intellectual-disability/
"Positive parenting can help children form secure attachment, which builds resilience and positive brain development. It can also help children to learn to use healthy coping skills and self-regulate"
http://www.thearc.org/what-we-do/resources/fact-sheets/parents-with-idd
The organization Arc takes care about the parents of children with intellectual disabilities-provides materials, webinars, publications, sharing experience with other parents

- **Webinars for parent s of children with ID-about support for child with ID and for siblings and to deal with challenges of growing up and aging**

http://aaidd.org/education/webinars#.Wjo579_iaUk
webinars organized by AAIDD organization members

http://aaidd.org/education/education-archive/2017/04/19/default-calendar/transitioning-roles-from-aging-parents-to-siblings-of-people-with-idd#.Wjo6Rt_iaUk
webinar organized by AAIDD organization members theme „Transitioning Roles From Aging Parents To Siblings Of People With I/DD".
https://thearc.webex.com/tc3200/trainingcenter/record/recordAction.do?actionType=Info&strformURL=1&tcRecordingLink=Yes&siteurl=thearc&RCID=d1a13228fb70a9be3514535bd12f893a&AT=RINF&siteurl=thearc&apiname=e.php&rnd=4231278641&servicename=TC&recordingID=18324032&needFilter=false&isurlact=true&entactname=%2Fe.do&entappname=url3200&renewticket=0
Webinar about Aging and Loss, and Hospice Care for Individuals with ID

- **Free applications and tools for parents of children with ID**
- On the following links you could find applications and software to support alternative communications for children who have communication and language problems.

http://uk.mayer-johnson.com/tips/details.aspx?id=207
http://uk.mayer-johnson.com/tips/details.aspx?id=178
http://uk.mayer-johnson.com/products/boardmaker-plus/
https://www.disabled-world.com/entertainment/mayer-johnson.php
https://www.speechandlanguagekids.com/aacpage/
https://www.speechandlanguagekids.com/cheap-easy-use-augmentative-alternative-communication-aac-devices/
https://www.speechandlanguagekids.com/picture-exchange-communication-system-pecs-non-verbal-children/

https://www.boardmakeronline.com/
http://usluge.ict-aac.hr/

Summary

In this chapter the reader will find definition of intellectual disability in terms of intellectual functioning and adaptive behavior. After that some other important terms in the field of intellectual disability are explained briefly. The data about the prevalence of intellectual disability and the causes are also presented in this chapter. The idea was then to present the functioning of children with ID and adult persons in family environment, in school environment and in interactions with peers or relations with others. Finally at the end of this chapter parents could find useful tips for their support of child with ID but mostly for support of parents in dealing with challenges of difficulties and how to provide some empower family relationships useful strategies for coping with challenges of having child with ID.

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Žic Ralić, A. (2014). Vršnjaci i djeca s teškoćama. U Igrić, Lj., Fulgosi-Masnjak, R., Wagner Jakab, A. (ur.), *Učenik s teškoćama između škole i obitelji* (str.41-56). Zagreb: Centar inkluzivne potpore IDEM.

2. Parenting Children with Cerebral Palsy

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Summary

Cerebral Palsy (CP) is most common developmental disorder. It is caused by brain damage which affects the development of most functions, especially the development of motor functions (position and/or movement). Problems in functions leads to problems in everyday functioning in different areas of life: education, activities of daily living, finding and keeping job, leisure time, etc. Kind and severity of problems in functions and functioning (i.e. disability) basically depends on brain lesion localization and size. Nevertheless, the influence of rehabilitation (especially early rehabilitation) cannot be ignored. Well planned rehabilitation methods and environmental changes can encourage persons' abilities and skills and improve persons' functioning in all life areas. Having a child with cerebral palsy will affect family life. Family will have to change their habits, perhaps even their living condition to remove barriers and improve child's ability to move around. It is important for family to find support in a community; from specialists, but also a parent group support.

What is Cerebral palsy?

Cerebral palsy (CP) is the most common developmental disorder associated with lifelong motor impairment and disability. It is thought to affect two to four individuals per 1000 of the general population (Aisen et al., 2011; Jan, 2006) That prevalence has remained remarkably stable over the last 30 years, particularly for term children who represent half of all children with cerebral palsy. (Cans et al. 2008)

Earlier definitions of cerebral palsy were focused on motor aspects and specific brain damage. Cerebral palsy is, however, associated with other impairments. Therefore, new definitions of cerebral palsy state that *it is a group of permanent disorders of the development of movement and posture, causing activity limitation, that are attributed to nonprogressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, perception, cognition, communication, and behavior, by epilepsy, and by secondary musculoskeletal problems.* (Rosenbaum et al. 2006). Hence, we can conclude that most children with cerebral palsy have multiple disabilities and develop wide range of functional problems.

Multiple disabilities – a combination of impairments (such as mental retardation-blindness, or mental retardation-physical disabilities) that causes such severe educational problems that the child cannot be accommodated in a special education program solely for one of the impairments. The term does not include deaf-blindness.

Among the various associated handicaps in cerebral palsy the most common is intellectual disability, followed by speech impairment, seizure disorder, visual impairment, and hearing impairment (Majumdar et al., 2006).

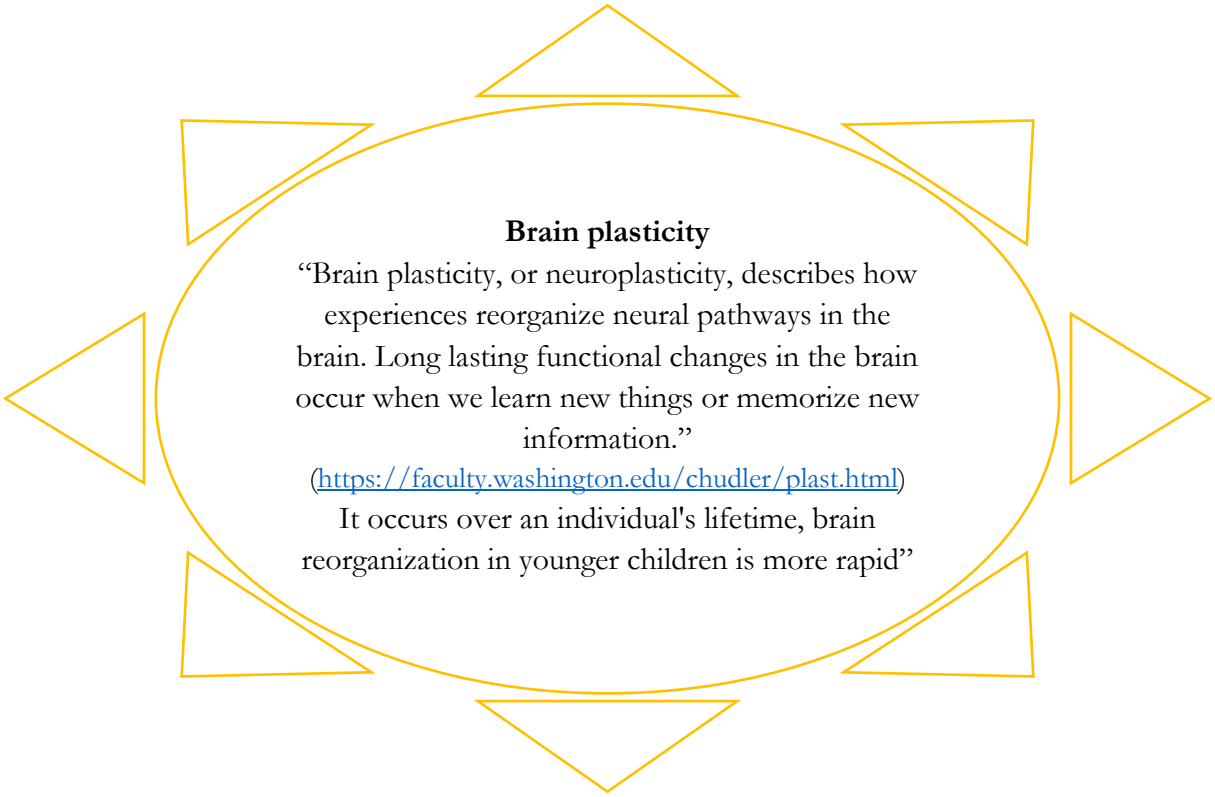
Cerebral palsy is the result of multifactorial events (Cans et al 2008) multiple births and specific health actions during early infancy may have an impact.

Main risk factors for cerebral palsy in term or near-term children include intrauterine exposure to infection or inflammation and disorders of coagulation Nelson and Grether (1999)
Common cause of cerebral palsy is a perinatal brain damage which can be caused by asphyxia, hypoxia, and infection. There are several types of brain damage depending on part of the brain tissue that is damaged and different levels of brain damage implicate the severity of damage.
Rddihough and Collins (2003) listed known causes of cerebral palsy so they discuss about congenital brain malformations, severe neonatal and postnatal infection and injuries.

Behaviors of children with cerebral palsy

The range of functional problems of children with cerebral palsy is basically determined by localization and a size of brain damage, nevertheless each child develops in their own way.

During our clinical work in early intervention, we had a chance to meet a boy with Periventricular Leucomalacia level III. According to his medical diagnosis, we expected a child with severe motor and additional problems, such as visual impairment, intellectual disability etc.
When we met a boy, he was 15 months of age. His mother was well supported from experts and knew how to handle him from birth. She encouraged his motor development, so he was crawling when we met him. He used several easy words and communicated well with those words and hand gestures. He manipulated objects with both hands and used them functionally. He ate solid food and had problems only with drinking water.
Now he is 5 years of age, attending regular kindergarten. He uses wheelchair to move independently outdoor and uses walker for indoor. He eats and drinks independently, communicates verbally and learns very quickly. So he is preparing for regular school.
When we think about this boy, we are considering several things and some of them are the importance of early intervention, but also that localization and severity of brain damage cannot be the only predictor of child's developmental problems. Sometimes child could "surprise" us with his/her functioning. Therefore we always have to take medical diagnosis with caution, to give us some insight, but not to be predictor of development, especially during early childhood, because of injury induced brain plasticity.



Children with cerebral palsy can have different functional problems and they need different levels of support.

In order to make diagnosis and rehabilitation planning easier, several classification systems have developed to describe functional abilities of children with cerebral palsy.

First classification system that was introduced to experts working with children with cerebral palsy was *Gross Motor Functional Classification System (GMFCS)*. It was presented by Palisano et al. (1997) and it is still in use. This Classification system defines gross motor problems of children with cerebral palsy through five levels of functioning with an emphasis on sitting and walking (Palisano et al.1997).

Following this classification of gross motor function, other classifications have been developed to define and classify other functions of children with cerebral palsy. All of those classification systems use five level scales.

One of them is *Manual Ability Classification System (MACS)*. It was developed to classify how do children with cerebral palsy use their hands when handling objects in daily activities. The classification is designed to reflect the child's typical manual performance, not the child's maximal capacity. It classifies the collaborative use of both hands together. (Eliasson et al. 2006)

Communication disorders can be described from several perspectives: traditional once, focused on body structure and function or from a perspective of activity and participation level, as well as environmental and personal levels specifically the way in which to classify a person's communication capacity within real-life situations (Hidecker et al.2011) During 2011. Hidecker et al. have developed *Communication Function Classification System (CFCS)* for individuals with cerebral palsy. The CFCS was empirically derived from the communication disorders literature and expert experience to classify patterns of an individual's communication performance in one of five levels of everyday communication effectiveness with a partner (Hidecker et al. 2011).

	GMFCS	MACS	CFCS	EDACS
I	Walks without limitations	Handles objects easily and successfully	Sends and receives with familiar and unfamiliar partners effectively and efficiently	Eats and drinks safely and efficiently

	GMFCS	MACS	CFCS	EDACS
II	Walks with limitations	Handles most objects but with somewhat reduced quality and/or speed of achievement	Sends and receives with familiar and unfamiliar partners but may need extra time	Eats and drinks safely but with some limitations to efficiency.

	GMFCS	MACS	CFCS	EDACS
III	Walks using a hand-held mobility device	Handles objects with difficulty; needs help to prepare and/or modify activities	Sends and receives with familiar partners effectively, but not with unfamiliar partners	Eats and drinks with some limitations to safety; maybe limitations to efficiency.

	GMFCS	MACS	CFCS	EDACS
IV	Self-mobility with limitations; may use powered mobility	Handles a limited selection of easily managed objects in adapted situations	Inconsistently sends and/or receives even with familiar partners	Eats and drinks with significant limitations to safety.

	GMFCS	MACS	CFCS	EDACS
V	Transported in a manual wheelchair	Does not handle objects and has severely limited ability to perform even simple actions	Seldom effectively sends and receives, even with familiar partners	Unable to eat or drink safely – tube feeding may be considered to provide nutrition.

Children and young people with cerebral palsy may have problems eating enough food and drinking efficiently. This influence their growth and health. Problems in eating and drinking are caused by problems in moving their mouths. Some of them will even have problems with frequent chest infections because particles of food or drink enter their lungs when they swallow. These difficulties continue throughout their lives. Since eating and drinking is important function, experts have to be able to diagnose and to classify those problems in order to develop good rehabilitation approach to eating and drinking problems. Therefore, during 2013. Sellers et al. developed *Eating and Drinking Ability Classification System (EDACS)* for individuals with cerebral palsy.

For many years definition or measurement of visual impairment was described only by structure of an eye or visual functions that were being assessed. Nevertheless, those results cannot always describe how a child with cerebral palsy functions in vision-related activities. Children with cerebral palsy often have ocular problems, but they can also develop problems in visual functioning caused by damage of the brain, which is known as *Cerebral Visual Impairment.*

To make classification of problems in visual functioning in children with cerebral palsy, and following the recommendation of World Health Organization group of authors introduced *The Visual Function Classification System (VFCS)*: a new classification system for visual function in children with cerebral palsy which is now in the process of development and validation.

Combining all mentioned classification systems in assessment and describing of functional abilities of children with cerebral palsy contributes to a functional performance overview of daily life for individuals with cerebral palsy.

Cerebral Visual Impairment (CVI) is a condition where some of the special 'vision' parts of the brain and its connections are damaged. This causes visual impairment even though the eyes are normal. Often children with CVI actually have good visual acuity but cannot 'make sense' of what they see. In most cases, once the damage has happened it does not get worse. As the child grows older the visual difficulties may slowly improve.

Children with CVI can have problems with:

Getting Around	Recognizing familiar faces
Recognizing Objects	Knowing what common everyday objects are
Focusing for near objects	Finding the way in places that should be well known to the child
Fast eye movements	Remembering things they have seen
Visual Field Loss	Imagining 'seeing' things in their minds
Use stairs without falling	Some children's vision can become 'tired' more quickly than others
Step onto pavements without tripping	Their ability to see can vary from one time to another
Reach forward and grab a cup or handle	Reading

(http://www.ssc.education.ed.ac.uk/resources/vi&multi/eyeconds/cereVI.html)

Depending on severity, or level of ability of a child with cerebral palsy they might have more or less support. Sometimes they need a lot of support from people around them, but they can benefit from assistive technologies too. There are many assistive technologies developed in order to help children and grownups with cerebral palsy and multiple disabilities to participate in different activities and community life.

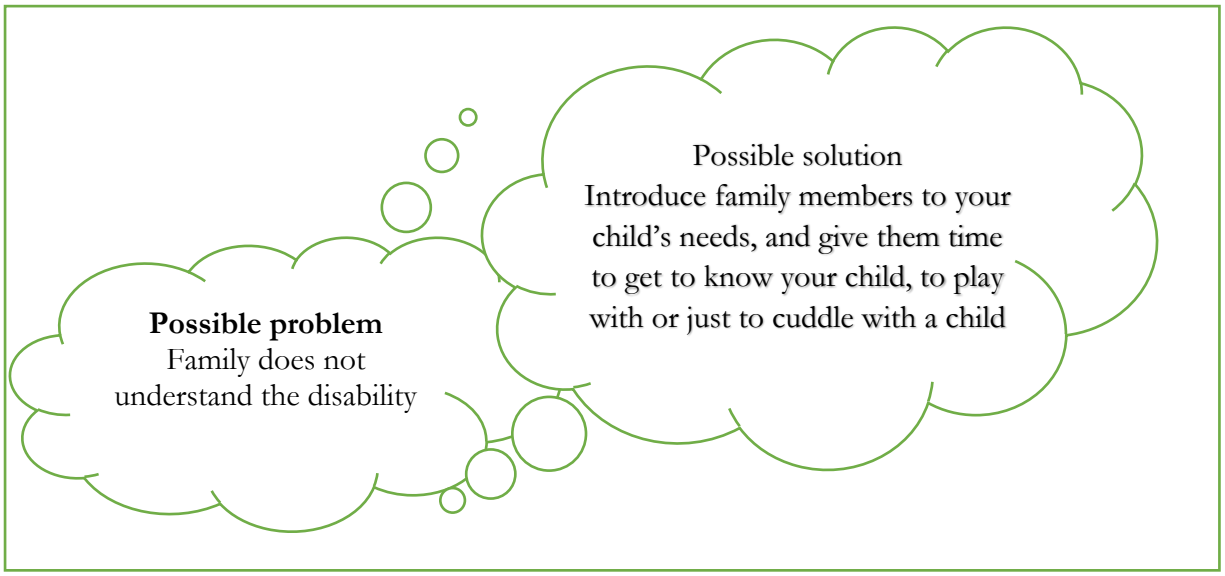
Having a child with Cerebral palsy

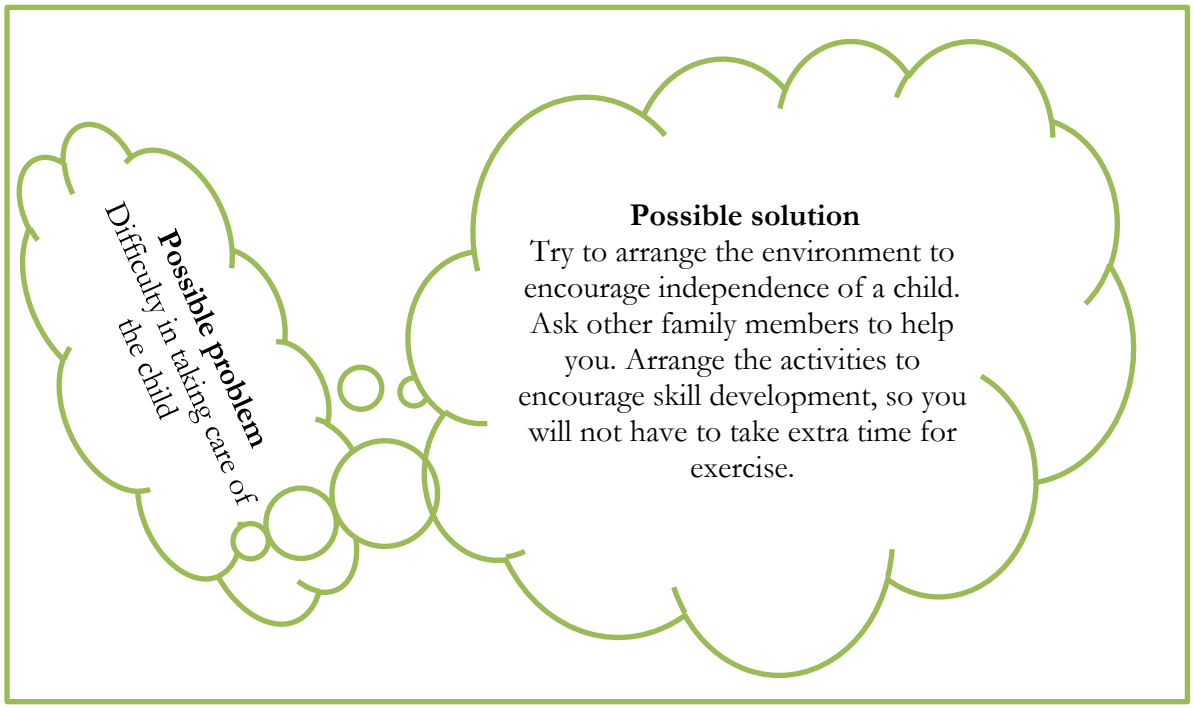
Parents of children with cerebral palsy often experience high levels of stress. Parents' functioning can be affected by behavioral aspects of the child with cerebral palsy (Ketelaar et al.2008). Research indicates that parents of children with cerebral palsy are more prone to depression, financial strain, relationship challenges, even divorce. Yet, on contrary, some people even think that it can bring relationships together with the purpose.

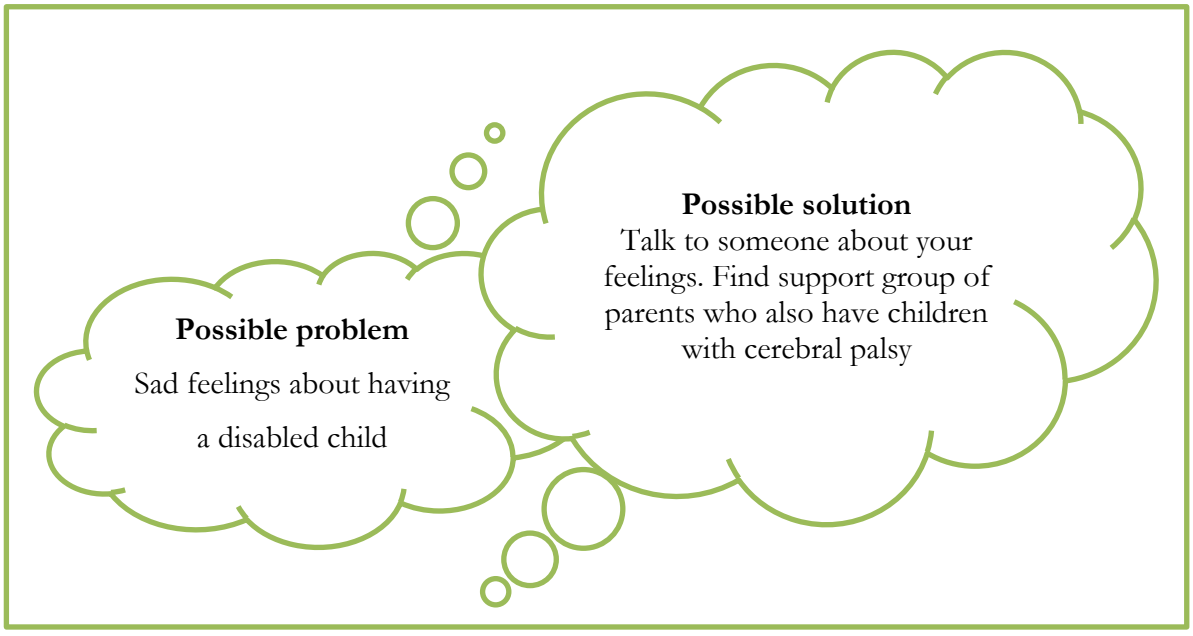
Embracing a life with cerebral palsy requires planning, organization, perspective, adaptation, and inspiration. Hopefully parents will not be alone in this, they have different experts to help them, medical doctors, physiotherapists, special education teachers, speech therapists and others.

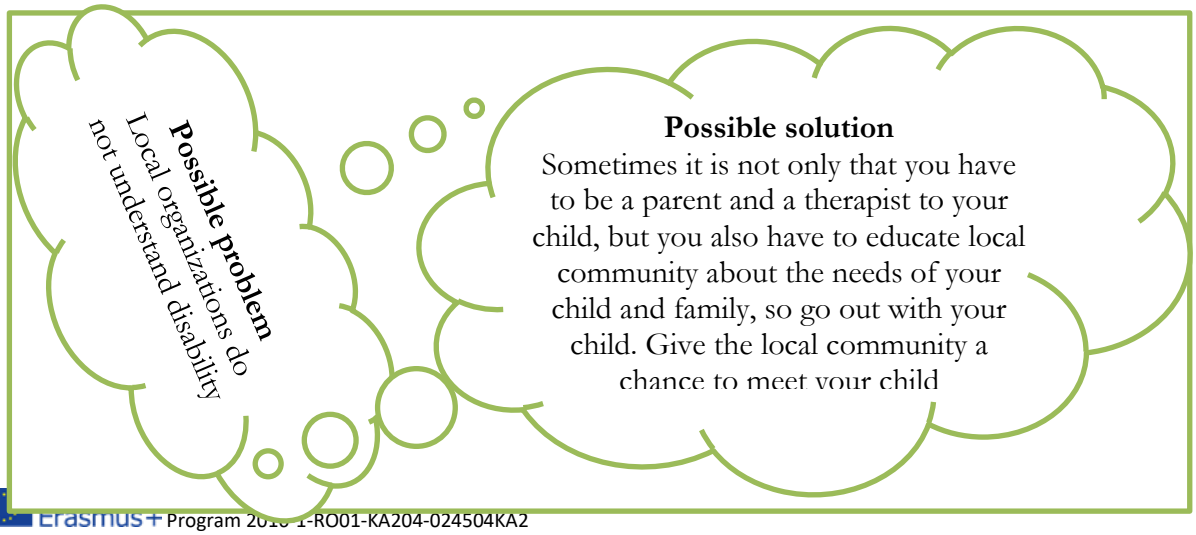
Nevertheless, we have to be cautious with the number of services and therapies child is involved in. Since families could be surrounded with a lot of experts, those days they have many therapies offered, even very early in life. Sometimes can happen that child is involved even in too many activities and it sometimes can be very stressful to a child but also to a parent. Sometimes they spend all day running around from one therapy to other. So parents have to be very careful when planning the activities for a child, and also for the whole family. It is important to have some time just to be together, to enjoy family life. Through those family activities, a child can learn a lot, if we adapt the environment and object used in activities we can also encourage skill development and learning, and the child is going to be happy.

This will also help parents to have more time, since parents of children with cerebral palsy spend more time in taking care of basic child's needs than parents of typically developing children. Children with cerebral palsy, especially the once who have more problems in motor skills, problems in chewing and swallowing, need more time to get dressed, to eat and to drink. And if you force them to hurry can not only make them unhappy, but even make them choke or hurt.




Possible problem
Difficulty in taking care of the child
Possible solution
Try to arrange the environment to encourage independence of a child. Ask other family members to help you. Arrange the activities to encourage skill development, so you will not have to take extra time for exercise.


Possible problem
Sad feelings about having a disabled child
Possible solution
Talk to someone about your feelings. Find support group of parents who also have children with cerebral palsy


Possible problem
Local organizations do not understand disability
Possible solution
Sometimes it is not only that you have to be a parent and a therapist to your child, but you also have to educate local community about the needs of your child and family, so go out with your child. Give the local community a chance to meet your child

Sometimes local community is not aware of children with cerebral palsy and their needs; therefore, they do not make the change. Sometimes it can even seem like if people from community have negative attitude towards child with disability and their family, but perhaps they are just not familiar with the problems family is facing and therefore they keep themselves away. Therefore parents of a child with cerebral palsy often stay alone and on a margin. It is important to include children in local community life, and community will start to accept the child. Parents could take a child to a children's theater, bookstore, cinema and other public places where a child can meet others and others can meet the child.

It is sometimes more stressful to parents to have their child scream in public than to drive the child around in a wheelchair. While the child screams, even from the joy and showing happiness, people start staring at the family of a child with cerebral palsy and that makes parents feel embarrassed. The best would be for parents to turn towards their child, not to look at other people and communicate with their child about his/her feelings. These way children will become aware of their feelings, and communication and learning will be encouraged.

During early years of life, parents and children experience a lot of separation, due to hospitalizations. Sometimes they have a feeling that they spend more time in hospitals than at home. Most children's hospitals these days are adapted to the needs of the whole family and make parents and children feel cozy during their stay. Still it is good to have something from their home which will make children and parents feel like home.

Furthermore, sometimes parents have to leave other child (if they have more than one child) at home while they are away. So a lot of support is needed from other members of family and people in community. But also, parents have to weight each time where will they be, with a typically developing child or with a child with cerebral palsy in hospital. Sometimes it is even fine to decide to spend the time with other child, and visit a child with cerebral palsy in hospital.

True story:

Once, I met one very courageous mother, and her story really inspired me. She carried twins, and went to a labour too early and a twin boy didn't survive. She got the birth of a lovely girl. I've met her when her daughter was 2 years of age. During the time I was a teacher to her daughter, she told me that when her daughter got born she has lost all of her friends. She was struggling with sadness and trying to get on with their lives, and she didn't even notice that at the beginning. Once she realized that her best friend hasn't called her for several months. As I mentioned, she was very courageous and she got the phone and called her friend asking: "Why didn't you call me for several months? After I came from the hospital, you called me only once." And her friend responded: "I feel so sad for what happened to you with your children. I can't ask you how your daughter is, when I know it is going to make you sad. And then it makes me sad, and I cannot call without asking about her. So I'm avoiding calling you." And our brave mother said: "Well you don't have to remind me on my and my daughter's problems, I'm aware of them every day, no one has to remind me with a question. Yet, it is easier for me if I can talk to someone, but if it makes you sad, we don't have to talk about my daughter. I would like to go on with our lives and I would like to have a friend to help me choosing the best jeans when I'm going for clothes shopping, and I need a friend to talk to about anything else, and I don't even have to talk about my daughter. I have experts to talk to about her problems."

After that, her friend started calling her every day, and they are still the best friends, for 15 year from then.

Tips for parents

Parents of children with cerebral palsy mostly wish their child to learn how to walk and how to talk, and this is very reasonable wish, since this helps a child to be more independent and to participate in age related activities. Nevertheless, independence in moving and communicating can be achieved in different ways. Therefore, it is important to use environmental, family and personal strengths to help children and persons with cerebral palsy to be as much as independent they can.

There are many products helping a child with cerebral palsy to move independently. From walkers for children who can walk with an assistance to electric wheelchair for a children on GMFSC level IV or V.

All parents will say that they understand every message their children wants to "tell" them, even without words or use of other forms of communication. Nevertheless, to ensure the participation in age related activities, a child has to learn how to communicate with others. It will help the child to be understood in kindergarten, at school, with friends. During last decades experts are designing and creating different approaches to communication. Previously, children were taught to speak, and these days the emphasis is on communication. It is important to find the best way how the child can express his/her needs and thoughts. This can be achieved by using words, gestures, pictures, pictograms, objects or more sophisticated technology. The form of communication has to be chosen according to child's motor, cognitive, tactual, visual, hearing and other abilities.

Children with cerebral palsy often have difficulties in fine motor skills which make them difficult to be independent in most of activities of daily living. Children can and they will exercise the fine motor skills, but to make them more independent, we have to adapt the environment. If they have problems in buttoning, we can give them the trousers, shirts, jackets and other cloths without

buttons, use rubber, Velcro, zippers or similar what they can open and close. The most difficult skill in dressing up is tying shoelaces, and most of children with cerebral palsy are not able to do it. Today we can buy elastic shoelaces, or shoes with Velcro, so children can be independent.

There are also a lot of possibilities for adapting the objects used in feeding and drinking. Sometimes it is enough to provide a cutlery with thick and weighted handle to improve holding of the spoon or fork. If it is not enough, there are more adaptations for fixing the cutlery for the hand. Children with cerebral palsy have problems in keeping their hand steady, so they can spill a lot of food, especially soups. Therefore, sometimes we have to find a bit deeper spoon or a spoon that prevents spilling.

By helping the child to be more independent in activities of daily living can help parents to enjoy those activities with a child, but also enables other family activities, like eating in restaurants, having dinner at friends etc.

Still, it is also important to expand child's mind, to teach the child about the world that surrounds them. Many times parents perceive academic achievement to be the most important for a future of a child. But for fostering child's intellectual development it is not enough only to think about academic knowledge. It is important to provide a lot of stimuli for encouraging the thinking. It can be done through very easy activities, like reading books, playing board games, or going to a museum or exhibition.

Even though academic achievement is important for a child, other experiences and activities are also important for development of emotionally happy person. Therefore, parents and experts working with a child have to think about child's need for having free time, playing with peers, or sometimes doing nothing. Children can meet potential friends and begin the process of socialization through activities and interaction with their peers. Find activities that a child may enjoy and that fit into his or her skill set and that are age appropriate. The simple process of getting to know other people through engagement and common interests helps the child see that he or she is capable of making friends.

Parents of children with cerebral palsy spend a lot of time taking care of their children, and they sometimes forget about their own needs. They forget to take some time for themselves to have some time without their child. Sometimes it is good for parents to spend some time alone with their spouse, to meet friends without thier children. To be able to do that, it is good to have some person of trust to be with a child. If a parent does not trust to a caregiver, they won't enjoy their free time. In some countries there are services of "babysitting / caregiving" for children with different kind of disabilities available. In Croatia parents can ask for a service of "babysitting" from the agency that provides those services for free. This agency gathers volunteers and provides them with short education about the needs of children with different disabilities. So those volunteers are trained not only for taking care about children, but also for encouraging their communication, learning, socialization etc.

Useful links:

http://www.cerebralpalsy.org/
https://www.cerebralpalsyguide.com/cerebral-palsy/
http://www.parentcenterhub.org/cerebral palsy/
https://www.cerebralpalsyguide.com/blog/tips-for-parents/
https://themighty.com/2016/10/advice-for-parents-of-kids-with-cerebral-palsy-from-an-adult-with-cerebral palsy/
https://www.webmd.com/children/cerebral-palsy-parenting#1
https://www.freewheelintravel.org/advice-parents-child-cerebral-palsy/
http://dergipark.gov.tr/download/article-file/62254
http://www.friendshipcircle.org/blog/2013/05/10/10-must-have-products-for-individuals-with-cerebral-palsy/

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3. Parenting children with autism and Asperger syndrome

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What is Autism Spectrum Disorder?

ASD is a developmental disability that appears early in a child's life. It is characterized by the presence of difficulties in two areas:

- *social communication and social interaction and*
- *behaviour* - repetitive behaviors or fixated interests. (for details see Frame 1)

The combination of strengths and difficulties is unique for every child with ASD. There is a famous sentence „When you meet one person with autism, you met one person with autism" that describes the diversity of needs and challenges of persons with ASD. Some people can have a lot of difficulties in everyday challenges and some have less. That can change during the lifespan, but also can vary depending on the specific situation or setting (in school, at home, in the supermarket).

What difficulties a child with ASD can have?

The child doesn't develop language or when he does, he is not using it in a usual way. He may have echolalia (repeats words or phrases that he heard before, or entire sentences from cartoons)

Children can have difficulties in conversation skills, in initiating, sustaining and finishing interaction with others.

Most children don't develop imaginative play, if some do, they may always use the same "story" and insist in their scenario, they may play with objects in repetitive manner, or explore it sensory (taste it, touch it). They often have difficulties in playing with peers.

Some children don't imitate peers or adults

Children can have difficulties in using eye contact. Some children don't make eye contact, some are using it only in certain situations (for example, when they are requesting), some can't make eye contact and listening to the others at the same time.

Some children don't express a range of facial expressions and it can be hard to figure out how do they feel, or what do they want. On the other hand, they also have troubles in "reading" non verbal communication of others. They can rely literally on what people are saying without taking into consideration of how people are using gestures, facial expressions and eye contact to convey a message. This can lead to awkward interactions and misunderstanding of another person's intent. Unfortunately, difficulty with nonverbal aspects of communication may be particularly challenging

with school-aged peers, who are often less tolerant of socially inappropriate behaviors than adults and have fewer strategies for managing difficult social interactions with a social partner.

These children often do not spontaneously seek out other people to "share" something important they are experiencing. They may not see the value in pointing out things they like or may not share their accomplishments.

The child may have difficulty with the social "give and take" between individuals. Some examples of how these challenges may affect social interactions include the following:

It may be difficult for younger children to share and take turns with toys or other preferred items.

Adolescents or adults may have trouble showing or expressing concern when someone is upset, or trying to offer comfort to that person. This does not necessarily mean a person on the autism spectrum doesn't notice when others are upset or doesn't want to support them. However, they might have difficulty understanding why someone is crying or distressed or may not be aware that their empathetic efforts might ease a difficult situation for someone else. They may simply be uncertain how to alter their behaviour to better meet the needs of others.

Repetitive behaviours or fixated interests can also have different forms in children with ASD. Children can have repetitive movements, like flicking of fingers in front of the eyes, rocking back and forth or using objects in a repetitive way. The other form can be that children are overly occupied with a single object, idea, or person. And finally, they can have difficulties with coping with changes in the environment (NAC, 2011).

Some facts about ASD

Autism spectrum disorder (ASD) and autism are both general terms for comprehensive developmental disorders that are characterized by difficulties in social interaction, verbal and nonverbal communication and repetitive behaviours. Previously, there were different types of that disorder (autistic disorder, childhood disintegrative disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS) and Asperger Syndrome), but since the publication of DSM – 5 (Diagnostic and Statistical Manual of Mental Disorders) (APA, 2013) they were all merged into one diagnosis of autism spectrum disorder.

Sometimes, the terms Kanner or Classic autism are used to describe the most severe form of the disorder.

For the child to receive a diagnosis of ASD he/she must have difficulties in at least six developmental and behavioural characteristics before the age of 3.

There are two domains where people with ASD show difficulties:

1) social communication and social interaction

2) restricted and repetitive patterns of behavior

More specifically, people with ASD have difficulties in social-emotional reciprocity, deficits in nonverbal communicative behaviors used for social interaction and deficits in developing, maintaining and understanding relationships. In addition, they have repetitive patterns of behavior, including stereotyped or repetitive motor movements, insistence on sameness or inflexible adherence to routines, highly restricted, fixated interests, hyper or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment. Symptoms can be currently present or reported in past history. The DSM-5 has an additional category called Social Communication Disorder (SCD).

This allows for a diagnosis of disabilities in social communication, without the presence of repetitive behavior. SCD is a new diagnosis and much more research and information is needed. There are currently few guidelines for the treatment of SCD. Until such guidelines become available, treatments that target social communication, including many autism-specific interventions, should be provided to individuals with SCD. (Autism Speaks, 2014)

prevalence of ASD is approximatelly 1: 100 (Fombonee et al, 2011)

44% to 52% of persons with ASD may have intellectual disabilities (http://www.autism.org.uk)

ASD is 4,5 times more present in boys than girls (some studies suggest 2:1, many girls are unrecognized because ASD presents different in women and girls (Gould and Ashton – Smith, 2011).

What causes autism spectrum disorder?

The answer to that question was not known until many researchers engaged in finding it. Today, we know that there are many causes, we can't just pinpoint one. Scientists have identified gene changes and mutations connected to ASD. In 20% of persons with autism, a specific genetic cause of ASD can be identified. However, most cases involve a complex and variable combination of genetic risk and environmental factors that influence early brain development. In other words, in the presence of a genetic predisposition to ASD, a number of non-genetic or environmental influences further increase a child's risk. The clearest evidence of these environmental risk factors involves events before and during birth. They include advanced parental age at time of conception (both mom and dad), maternal illness during pregnancy, extreme prematurity, very low birth weight and certain difficulties during birth, particularly those involving periods of oxygen deprivation to the baby's brain. Mothers exposed to high levels of pesticides and air pollution may also be at higher risk of having a child with ASD. It is important to keep in mind that these factors, by themselves, do not cause autism. Rather, in combination with genetic risk factors, they appear to modestly increase risk. While the causes of autism are complex, it is abundantly clear that it is not caused by bad parenting (Autism Speaks, 2014)

Parent to parent

(the sections highlighted in green boxes in this chapter are taken over from NAC, 2011 without changes as this are valuable perspectives of parents)

Parent to parent

Years ago, few people knew about ASD, and treatment was very limited. Unfortunately, parents — particularly mothers — were often accused of causing their children's symptoms. They were labeled "refrigerator moms" who failed to respond to the needs of their children. It was much more difficult for these parents to network and get support from each other. Friends and family members who weren't familiar with autism often walked away from relationships with these families because they didn't know what to do.

Due to extensive coverage in the media, many more people know about ASD than in the past. But this coverage doesn't always convey the complexities of autism. That means that you're still

likely to encounter professionals, friends, and communities with an inaccurate or incomplete understanding of your child's disorder or the impact it has on your family. Don't be afraid to become an advocate for your child and an educator for your friends and your community. Many people simply require more information, or need to understand your experiences in order to become a source of support for you and other families who have loved ones with ASD. (NAC, 2011, page 22)

How is ASD diagnosed?

There are no medical tests for diagnosing ASD, diagnosis is still based on the child behaviour in different situations.

Elements of the diagnostic assesments are usually the following:

1. Clinical interview and observation
2. Using specific tests/critera for autism spectrum disorders
3. Cognitive/developmental assessment
4. Measurement of adaptive functioning
5. Specific biomedical tests (see Filipek et all, 2000)

ADOS (Autism Diagnostic Interview-Revised; Rutter, Le Couteur i Lord, 2003) and ADI – R (Autism Diagnostic Interview-Revised; Rutter, Le Couteur i Lord, 2003) represents a golden standard for autism diagnosis and it is recommended that one of those is incorporated in the diagnostic assessment.

How to manage interventions?

The process of finding effective treatment can be overwhelming and exhausting for parents! There are numerous treatments, promises of magic cure that are offered and no clear pathway in support system. A mother of a boy with ASD writes "Above all, I learned that we parents, no matter how much we long for a panacea must allow ourselves to be guided by something other than our own panicky need for instant answers. We must allow ourselves to be guided by our own God-given reason, our gift of logic as well as our hope and our prayers…" (Maurice, 1996, page 6).

Without a doubt, you are the most important expert in your child's world. You can provide a detailed account of your child's life, strengths, the challenges he currently faces, and the obstacles he has overcome. This detailed knowledge will be important to the professionals you work with, so it is important for you to collaborate effectively with the other experts on your child's team. Experts should appreciate your unique expertise, and you can greatly benefit from their professional knowledge and experience (NAC, 2011).

There are many evidence based treatments (for information see NAC, 2011 and NAC, 2015) but they may not be easily available or recognized. Far too many treatments that exist are not conducted in line of what is called good autism practice and far too many treatments are not evaluated at all. It is important that a professional who works with your child collects data before, during, and after treatment because it can help you and her/him to assess whether the child is making progress. Without clear data showing that a treatment leads to improvements of your child's skills, you may waste a lot of time on a treatment that isn't working for your child.

What is important is that you ask every treatment provider:

What does this treatment consists of? What is it supposed to do? How will you evaluate the treatment, how will I know if this treatment is effective for my child?

And if you are offered extensive medical examinations that can be stressful or aversive for your child, you can ask the following:

Why do you need that information? What will happen when I will know the results? Is it just to have information or will there be indication for change in my child's treatment? Will there be any change in my child's life if I will know that information? What will happen if don't do that examination?

Effective educators and therapists will not be afraid to have you participate in your child's treatment process. Don't hesitate to ask if you can do a few observations when the professional is treating your child. It is perfectly reasonable for you to observe your child's performance and the way the treatment is being implemented. (NAC, 2011)

If your presence affects a child's behaviour a lot, you can ask the professional to take a video of session so you can observe it.

We live in a culture that often tells us not to question the authority of healthcare providers. But keep in mind that some healthcare providers may not have a great deal of experience or comfort with providing care to a child with ASD or other special needs. It's perfectly acceptable to take the time to identify options, talk to other families, and be honest about your concerns. You might even need to have materials ready to educate the healthcare provider! As you do with all other professionals caring for your child, be respectful, listen carefully, engage in a candid dialogue, and advocate for your child when needed (NAC, 2011).

Parent to parent

Understanding the behavior of typically developing children is important because we sometimes hold our children with ASD to a different behavioral standard than their peers. Some parents or families set expectations too low and others may set expectations too high. Ask yourself if a typically developing child would do the same thing on the playground or at the dinner table. Would this behavior draw attention or be perceived as inappropriate? Expectations for our children with ASD should never be so low that they do not develop skills that will allow them to reach their potential and participate in community activities. But children with ASD should also not be singled out for unreasonably high expectations — all kids occasionally make bad choices, and many of these choices do not require extensive examination.

Use structure

Structure seems to help many children with autism to manage their environment. It's often much more difficult for parents to provide the same structure at home that a child may have at school. This is often due to other children who need care, job requirements, cooking or cleaning responsibilities, and a parent's legitimate need for personal relaxation. Remember that it may be difficult to provide structure during holidays or other extended breaks from school. Special planning and preparation can make a big difference.

Parent to parent

Your child will likely benefit from added structure at school, at home, or in the community.

- At school, your child may need help completing larger assignments (such as book reports or science experiments) or participating in group activities that require him to interact with peers to complete a project. He may also need more time to complete tests, assistance with writing down the answers, and a testing area with reduced distractions, etc. Not all school professionals will realize that your child will benefit from these kinds of modifications. This is particularly true if you have a child who appears to be better at communicating than she actually is. This means you may need to advocate on your child's behalf. Your child will likely benefit from added structure at school, at home, or in the community.
- At home, you might want to structure homework time, modify chores by providing specific instructions, create checklists for your child, etc. We realize it may seem overwhelming to put all sorts of new strategies in place. But if your child needs a lot of structure to be successful, remind yourself how much easier things will be once you provide that structure.
- Community outings are naturally less structured. Using Schedules and Story-based Interventions can be a great way to help your child prepare for these activities. (NAC, 2011)

Siblings

Having a brother or sister with autism can be challenging and complicated at times. Siblings of children with autism may feel neglected, embarrassed, and confused. As a parent you can listen to the concerns and fears of your children and help them understand and accept the uniqueness of your family (Timmons, Breitenbach and MacIsaac, 2006).

Siblings may need the following supports (Wheeler, 2006):

• Communication from parents that is developmentally appropriate, factual, and ongoing. They must know that communication within the family is encouraged.

• Attention from parents that is not related to their brother or sister with ASD. They may need time to engage in "normal" family activities.

• Information about how to interact with their brother or sister in ways that are similar to other sibling pairs.

• Choices about how involved they should be in the care and treatment of their brother or sister with ASD.

• To feel safe and know that they will be protected from behaviours their sibling with ASD might exhibit.

• Appropriate time and support to deal with their own feelings about their brother or sister's diagnosis.

• Interactions with other siblings of children with ASD to share their experiences.

• Just as parents need help, siblings need guidance on how to respond to questions about their brother or sister's disability.

Care for Yourself!

Parent to parent

Don't feel guilty if you need to leave your child with a sitter while the rest of your family sees a movie. Sometimes this is best for the entire family! Have your child's team help him develop the

skills he needs to go to the movies with the rest of the family, but don't make the rest of the family wait indefinitely while these skills are being developed.

Parenting is difficult. Parenting a child with ASD carries unique challenges and stressors. Parents of children with ASD often report significant stress as they manage their child's care. Common activities, such as shopping and dinners out with the family, can be difficult.

Supporting a person with ASD can place significant strain on a family's physical, financial, and emotional well-being. Parents may experience stress as they decide how to allocate their attention and energy across family members. Parents may feel the strength of their marriage or interpersonal relationships is challenged, or feel guilt about the limited time they spend with their other children, when so much of their attention is focused on the child with ASD. It would be easy to focus all of your energies on your child with ASD, but it's in his or her best interest for you to have the resilience that comes from remaining connected with other adults who care about you and your child. These relationships may exist in your household, but might also exist with friends, colleagues, or other people who have a sustained interest in your well-being.

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4. Parenting children with learning disabilities

Having a child with learning disabilities (LD)

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Abstract

Learning Disabilities (LD) refer to a number of disorders which may affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities. Learning disabilities range in severity and may interfere with the acquisition and use of one or more abilities in fields of oral language, reading, written language and mathematics. They are much more complex then they looked like on the first sight because they affect children's self-concept, social competence and self-awareness. Furthermore, LD affect family dynamic and become family affair. We hope that this chapter will be supportive and helpful to families in that child has LD. Just becoming aware of some issues that bothers children, parents, siblings can be a good start for making some positive improvements.

Has your child been diagnosed with a learning disability? Did you immediately begin to worry about how she or he will cope with school? Evendough it is natural that you want the best possible academic success for your child it is not the final goal. In a big picture what you actually want for your child is a happy and fulfilling life. With encouragement and the right support, your child can build a strong sense of self-confidence and a solid foundation for lifelong success.

Maja, 12 years, has reading and writing disability, difficulties in attention, working memory and speed information processing. She has right to IEP. She has difficulties in understanding texts, in learning new concepts; in naming, understanding time-space relation. She has problems with multiplication table. Because some teachers criticize her and don't follow IEP Maja has also psychosomatic problems (headache, stomach distress etc.) and anxiety. Maja is very successful in painting, crocheting, making toys. Maja is interested in experiments, science and new research. Maja is not giving up even while doing the most difficult tasks, but increasingly showing resistance with writing tasks, especially those which she claims cannot. She faces misunderstanding from friends and surroundings –they are convicted that she doesn't have disability, but does not work enough at home. She is suffering greatly for good friend. Friendship fails to take place, which brings great disappointment. She attends peer workshops in one center for fostering social competence and dealing with disabilities Parents are very attentive and although very often face a lack of understanding from others they are perfect advocates for their child.

What are learning disabilities?

Adopted by the Learning Disabilities Association of Canada January 30, 2002) Re- endorsed on March 2, 2015

Learning Disabilities refer to a number of disorders which may affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning. As such, learning disabilities are distinct from global intellectual deficiency.

Learning disabilities result from impairments in one or more processes related to perceiving, thinking, remembering or learning. These include, but are not limited to: language processing; phonological processing; visual spatial processing; processing speed; memory and attention; and executive functions (e.g. planning and decision-making).

Learning disabilities range in severity and may interfere with the acquisition and use of one or more of the following:

- oral language (e.g. listening, speaking, understanding);
- reading (e.g. decoding, phonetic knowledge, word recognition, comprehension);
- written language (e.g. spelling and written expression); and
- mathematics (e.g. computation, problem solving).

Learning disabilities may also involve difficulties with organizational skills, social perception, social interaction and perspective taking.

Learning disabilities are lifelong. The way in which they are expressed may vary over an individual's lifetime, depending on the interaction between the demands of the environment and the individual's strengths and needs. Learning disabilities are suggested by unexpected academic under-achievement or achievement which is maintained only by unusually high levels of effort and support.

Learning disabilities are due to genetic and/or neurobiological factors or injury that alters brain functioning in a manner which affects one or more processes related to learning. These disorders are not due primarily to hearing and/or vision problems, socio-economic factors, cultural or linguistic differences, lack of motivation or ineffective teaching, although these factors may further complicate the challenges faced by individuals with learning disabilities.

Learning disabilities may co-exist with various conditions including attentional, behavioural and emotional disorders, sensory impairments or other medical conditions.

For success, individuals with learning disabilities require early identification and timely specialized assessments and interventions involving home, school, community and workplace settings. **The interventions need to be appropriate for each individual's learning disability subtype and, at a minimum, include the provision of**:

- specific skill instruction;
- accommodations;
- compensatory strategies; and
- self-advocacy skills.

Glossary

Dyslexia. A language- based disability in which a person has trouble understanding written words. It may also be reffered to as reading disabilities or reading disorder.

Dyscalculia. A mathematical diasability in which a person has a difficult time solving arithmetic problems and grasping math concepts.

Dysgraphia. A writing disability in which s person finds it hard to form letters or write within a defined space.

Auditory and visual processing disorders. Sensory disabilities in which a person has difficulty understanding language despite normal hearing and vision.

Nonverbal learning disabilities. Problems with visual-spatial, intuitive, organizational, evaluative and holistic processing functions and social/emotional issues.

(Davis, Broitman, 2011, pg. 3)

How many children have LD?

Learning disorders are among the most frequently diagnosed developmental disorders in childhood. Epidemiological studies report comparable prevalence rates of 4–9% for deficits in reading and 3–7% for deficits in mathematics with higher prevalence rates for boys than girls (Moll, Kunze, Neuhoff, Bruder, Schultze-Korne, 2014). Learning disabilities are often coming together (30-50 %) with Attention Deficit Hyperactivity Disorder (ADHD).

How can you recognize that your child has troubles with learning?

When a child has a learning disability, he or she (http://www.parentcenterhub.org/ld/):

- may have trouble learning the alphabet, rhyming words, or connecting letters to their sounds;
- may make many mistakes when reading aloud, and repeat and pause often;
- may not understand what he or she reads;
- may have real trouble with spelling;
- may have very messy handwriting or hold a pencil awkwardly;
- may struggle to express ideas in writing;
- may learn language late and have a limited vocabulary;
- may have trouble remembering the sounds that letters make or hearing slight differences between words;
- may have trouble understanding jokes, comic strips, and sarcasm;
- may have trouble following directions;
- may mispronounce words or use a wrong word that sounds similar;
- may have trouble organizing what he or she wants to say or not be able to think of the word he or she needs for writing or conversation;

• may not follow the social rules of conversation, such as taking turns, and may stand too close to the listener;

• may confuse math symbols and misread numbers;

• may not be able to retell a story in order (what happened first, second, third); or

• may not know where to begin a task or how to go on from there

Child with LD at home (family dynamic)

Frequently parents become aware of a child's problem after he or she begins elementary school. You may have had some earlier suspicion that something was not quite right but no one really talked about it until the difficulties at school became obvious. There also may be resentment between parents. One may feel that the other is responsible for the child's dysfunction. It might be that one of the spouse also had problems as a child. It is often heard

"He is just like his dad and grandfather". Furthermore, mothers often have a sense that something is wrong with their children but fathers feel that mothers parenting style is too mild and that children are simply spoiled and needed more discipline or exercise in reading, writing or calculating. That could make both parents frustrating and lead them in conflicts. They might become more like enemies than allies.

Getting the diagnosis is beginning of provision of a good support to child and its family. Initial reactions to hearing of their children's learning disabilities differ from relief to more often shock, disbelief and anger-at the teacher, the school and particularly at child (Osman, 1997).

Accepting the idea of a child's disabilities is an on-going painful process for parents. It doesn't happen all at once during one conference with experts. Emotional responses of parents differ from blame and resentment, denial, disappointment to large or even too large involvement in educating child.

Parental roles and participations are usually different. Although fathers today are more involved and ready to take responsibilities then in past generations, mothers still tend to be more "in charge" even if they work full time. That can lead to strong mother/child alliance and exclusion of father. Often fathers' intervention carries more weight in schools. When it comes to the legal aspects many fathers become instant advocates for their children. Fathers have a special role for their children with LD. They are important role models to them. Furthermore, many fathers have a talent for helping with homework. Mothers may be tired and if father is not involved they can burn-out. It is important to both of them to involve in their child's schooling and life and become a strong team that support their children (Osman, 1997). Furthermore it is also important that parents secure some individual space as well as their marital space for them as a partners (Marshak, Pollock Prezant, 2007).

School period of children with learning disabilities is extremely stressful for whole families. Since those children are average or even above average intelligent parents strongly support children to achieve as much as possible school success. Sometimes it becomes central focus in families for many years. Instead of common family activities members are involved and work hard to help child with LD to achieve school success. It might become problem if parents become lousy teachers instead of good parents.

Children's learning disabilities are family affair. Some of the loudest messages that children receive from their parents remain unspoken. Children are aware of parent's frustrations,

disappointment, anger or sadness even parents try to hide them. Whether a family discuss the problems openly or keeps them aa secret, everyone in the family responds in some way to a child's disability (Osman, 1997).

Parents often feel quilt and called out for children behavior or results. Since their children achieve less success in some academic, emotional or social areas then it is expected, people that surround them often question parenting styles and relate them with children's behavior. That makes situation even more challenging.

Siblings are also affected with disabilities of brothers and sisters. All sorts of emotions and thoughts overwhelmed them.

They may fear that their sibling's problem is contagious, they can feel quilt about their own school success, they are witnessing conflicts it families, they feel under pressure to succeed, they feel lack of time and energy of parents towards them, they feel pressure and responsibility to help their siblings in homework and they often do not feel that they have space to share their feelings about that. Grandparents feel generation gap and often do not understand what is going on. In their times there was not such a thing such as LD. They do not worry only for their grandchildren with LD they also suffer because the fact that their children has such a challenge in parenting their children.

Child with LD in the school

Almost all children with LD have difficulties in learning and fulfilling school requests. Those difficulties results from their primary neurobiological caused disorders like attention disorder, difficulties in reading, writing, calculating, retaining information, in perception, organization etc. If teachers don't know and don't understand that child has in fact some disability they will put such demands on that childlike on every other child without difficulties. But the child with LD will fail to fulfill some of this demands-like for example to understand given instructions, rewrite from the blackboards, or to write from dictation, to solve all the tasks in a specific time, understand what is written in the text etc. Very often in those cases teachers' think that child is just lazy or spoiled and that affects the relationship toward this child.

Children with LD needs such demands that they can fulfilled despite the disabilities. There is no question about can they learn but how can they learn, what do they need to learn. That's why good individualized educational plan (IEP) is needed.

IEP contain support plan and such adaptations needed for achieving the goals. If the IEP is not implemented and child don't get support, secondary difficulties can arise, such lack of self-confidence, lack of motivation for learning emotional difficulties like anxiety, depression and behavior problems. This so called secondary difficulties affects also learning in negative way and child is caught in a so called vicious circle.

Parents should have big role in planning and evaluating the IEP. They do know how the child learn at home, what helps him/her, what are the child interests etc. and therefore can help the teachers and special educators to make the best IEP for the child.

Except the problem in the school children with LD have big problem learning at home, especially in doing school homework.

Homework also has to be adopted to children needs, otherwise children are not motivated to do, prolong the time to do or not doing at all. Children with LD have also lack of knowledge how to learn. They have problems organize the learning, setting the goals, monitoring the learning and many of them didn't adopt adequate learning strategies. That's why homework and learning at home are

also the cause of frustration and conflict between parents and the child. Very often learning and doing homework last for hours and both children and parents are exhausted, frustrated and in stress. It's important to emphasize that we cannot learn and be successful enough while feeling stress and anxiety. If children spend all afternoon on learning they don't have time to do some other activities in which they could be successful and have fun. They don't have enough time for play and for physical activates which are very important for development. Learning how to learn and adequate demands for homework have to be part of IEP.

Children need support in learning and parents' should care for child's commitments. It affects child success. But, parents shouldn't be the only one who give support in learning and do homework with children. Otherwise the only thing they do together with children would be wrangling about homework. More important is to spend time with the children, having fun and enjoying in doing thing together.

Child with LD and peers

Many children with LD can have difficulties in interaction with peers due to several reasons. Some of them have difficulties in social skills, they lack skills how to communicate, how to respond on someone reaction, how to continue dialogue. Many of them have difficulties in verbal understanding which is important in interaction with peers. Some children are unaware of the effect of their actions and how other people respond to them. Due to attention problems they could be inattentive in a game or in a conversation. Some children know the social rules and they have skills but sometimes react impulsively. Some children because of school failure could lack self-esteem, feel frustrated and therefore start to withdraw or to act aggressively. It could happen that other peers start to avoid the child with LD because of their differences. Some children with LD became also victims of bullying. Many of children with disabilities feels lonely which have impact also on school success and could lead also to health problems.

Therefore, it's important to give support to child with LD to practice social skills and make opportunities and help with developing friendship. It's also important to work with the peers to understand and accept differences between children. Bullying prevention programs are also needed.

What can parents do? Besides professional support which they can and should seek and request they can also help their child. Parents can encourage their child to make contacts and help child to learn how to behave with peers, what's important while playing with other children, how to communicate and how to react in a case of bullying.

Here are some advices which can help you and your child:

• when your child talks about his troubles, don't blame him or try to diminish child problem. Try to understand, acknowledge child pain and help with the situation.

• You can ask your child how could he/she try to be someone's friend and help him/her to look head-on requirements for successful relationship.

• You could set standards for behavior and help the child with self-control

• Expose the child to all kinds of social situations and talk with him/her after. You can ask the child „What did you see?'", „What did you learn? ". Give praise to child for things he/she did right.

• Be patient and give the children time for learning social skills-Some children take longer to become ready for social interaction.

• Let your house be welcoming to other children. Supervise children carefully.

Support for you

There are lot of good suggestions for parents of children with LD available on Internet. We chose some of them and present them for you!

Tips for dealing with your child's learning disability

(https://www.helpguide.org/articles/autism-learning-disabilities/helping-children-with-learning-disabilities.htm)

Tip 1: Take charge of your child's education!

Don't sit back and let someone else be responsible for providing your child with the tools they need to learn. You can and should take an active role in your child's education. Understanding special education laws of your country and your school's guidelines for services will help you get the best support for your child at school. Your child may be eligible for some kinds of accommodations and support services, but the school might not provide services unless you ask for them. It is important for you to investigate all possibilities that you can use for a benefit of your child. If there are no possibilities that could be opportunity for you to associate with other families in similar situation and start to talk and ask for it.

Tip 2: Identify how your child learns the best

Everyone—learning disability or not—has their own unique learning style. Some people learn best by seeing or reading, others by listening, and still others by doing. You can help a child with a learning disability by identifying his or her primary learning style. Is your child a visual learner, an auditory learner, or a kinesthetic learner? Once you've figured out how he or she learns best, you can take steps to make sure that type of learning is reinforced in the classroom and during home study.

Tip 3: Think life success, rather than school success

Success means different things to different people, but your hopes and dreams for your child probably extend beyond good report cards. Maybe you hope that your child's future includes a fulfilling job and satisfying relationships, for example, or a happy family and a sense of contentment.

The point is that success in *life*—rather than just school success—depends, not on academics, but on things like a healthy sense of self, the willingness to ask for and accept help, the determination to keep trying in spite of challenges, the ability to form healthy relationships with others, and other qualities that aren't as easy to quantify as grades and scores.

Tip 4: Emphasize healthy lifestyle habits

It may seem like common sense that learning involves the body as well as the brain, but your child's eating, sleep, and exercise habits may be even more important than you think. If children with learning disabilities are eating right and getting enough sleep and exercise, they will be better able to focus, concentrate, and work hard.

Encouraging healthy emotional habits

In addition to healthy physical habits, you can also encourage children to have healthy emotional habits. Like you, they may be frustrated by the challenges presented by their learning disability. Try to give them outlets for expressing their anger, frustration, or feelings of discouragement. Listen when they want to talk and create an environment open to expression. Doing so will help them connect with their feelings and, eventually, learn how to calm themselves and regulate their emotions.

Tip 5: Take care of yourself, too

Sometimes the hardest part of parenting is remembering to take care of you. It's easy to get caught up in what your child needs, while forgetting your own needs. But if you don't look after yourself, you run the risk of burning out.

It's important to tend to your physical and emotional needs so that you're in a healthy space for your child. You won't be able to help your child if you're stressed out, exhausted, and emotionally depleted. When your calm and focused, on the other hand, you're better able to connect with your child and help him or her be calm and focused too.

Your spouse, friends, and family members can be helpful team mates if you can find a way to include them and learn to ask for help when you need it. **Communicate with family and friends about your child's learning disability**

Being a vocal advocate for your child can be challenging. You'll need superior communication and negotiation skills, and the confidence to defend your child's right to a proper education. So we found some tips that can support your communication with school! (https://www.helpguide.org/articles/autism-learning-disabilities/helping-children-with-learning-disabilities.htm)

Tips for communicating with your child's school:

Clarify your goals. Before meetings, write down what you want to accomplish. Decide what is most important, and what you are willing to negotiate.

Be a good listener. Allow school officials to explain their opinions. If you don't understand what someone is saying, ask for clarification. "What I hear you saying is…" can help ensure that both parties understand.

Offer new solutions. You have the advantage of not being a "part of the system," and may have new ideas. Do your research and find examples of what other schools have done.

Keep the focus. The school system is dealing with a large number of children; you are only concerned with your child. Help the meeting stay focused on your child. Mention your child's name frequently, don't drift into generalizations, and resist the urge to fight larger battles.

Stay calm, collected and positive. Go into the meeting assuming that everyone wants to help. If you say something you regret, simply apologize and try to get back on track.

Don't give up easily. If you're not satisfied with the school's response, try again.

Attend meeting with your partner- if you and your partner are good team members attend school meeting together. In that way school stuff will recognize you as a good team. Partner's perspective can also help you in understanding situation.

Recognize the limitations of the school system

Parents sometimes invest all of their time and energy into the school as the primary solution for their child's learning disability. It is better to recognize that the school situation for your child will probably never be perfect. Too many regulations and limited funding…. Try to recognize that the school will be only one part of the solution for your child and leave some of the stress behind.

It is very important to nurture open, honest and supportive communication between you and your child with LD. Sometimes it may seems challenging so we offer you some:

Tips for Talking to Your Child About Learning Disabilities

"Everyone has strengths and weaknesses."

Talk to your child about what *you're* really good at and what isn't as easy for you. Then ask him what he's good at and what is hard for him. Let your child know that we all have strengths and weaknesses, and give specific examples. When your child is struggling, it can be easy to make his challenges a primary focus. It's important that he knows his successes and interests say more about him than his challenges. Point out your child's strengths, using specific examples when possible

"A disability is a difference."

It's important to explain to your child how the word disability is used. A disability is a difference that makes it difficult for someone to do something that others can do easily. But that doesn't mean that person has difficulty with everything. And it's important to make that point to your child.

"Some differences are easily seen, and others are not."

It's important to point out to your child that learning and attention issues aren't always obvious. But they do show up in situations that can make things hard for your child. That doesn't mean it doesn't exist at other times—just that it's not something people always see.

"You just think differently."

Your child may worry that he is stupid or that his brain is going to "get worse" over time. Talk to him about the idea of thinking differently. And don't shy away from explaining the difference between learning disabilities and intellectual disabilities.

"It's OK to talk to me about your concerns."

The most helpful thing you can do is listen to your child's questions and concerns. Being empatic and listening to what your child says is very important. Respect his or hers feeling, understand that sometimes your child thinks about itself as stupid or looser. Try not to skip its bad feelings because it makes you feeling lousy. Give him or her space to talk about it. It will make space for him/her to see situation more realistic and to build trust toward you.

For more information visit www.understood.org/en/learning-attention-issues/understanding-childs-challenges/talking-with-your-child/how-to-talk-to-your-child-about-learning-and-attention-issues

If you have more children, you probably worry how this family situation affect them! In that case you can find some useful tips.

Tips to Help Parents Talk to Children About a Sibling's Learning Disability
(http://www.johncardinaloconnorschool.org/tips-to-help-parents-talk-to-children-about-a-siblings-learning-disability/)

An Unequal Distribution of Parental Time

Failing to talk to kids about their sibling's learning disability can lead to resentment. The additional time and attention parents give to the child with a learning disability can make the unaffected sibling feel ignored or less important. Sometimes children are expected to take on more responsibilities to account for the greater demands on the parent. Bringing the learning disability out into the open and making siblings a part of the solution can have a better result. Below are some tips on how parents can discuss the LD with their other children.

• **Explain What Caused the LD** – Depending on their age, the other children may be afraid that the LD is an illness or a punishment for being bad. They might fear they can "catch" it from their sibling. Explain that their sibling's brain works differently than theirs, so that it takes different types of teaching to help him or her learn. Add that schools have specially trained educators who can help their sibling learn in the way that is best for him or her.

• **Call It What It Is** – Refer to the learning disability by name and use it in conversation whenever appropriate. If parents need to meet with teachers to discuss their child's progress with the LD, tell the siblings that you need to meet with teachers to discuss their sibling's LD.

• **Distinguish "Different" from "Worse"** – Explain that although their sibling learns differently, he or she is not worse than other kids the same age, and no other child is better.

• **Help Them Understand How to Respond to Other Kids** – The conversations you have with your children will help them understand the time and attention you must devote to a child with a learning disability, but they may still feel uncomfortable if their peers ask questions or make inappropriate remarks about their sibling. Extend the conversation to concerns they may have over what other kids are thinking or saying.

• **Give Them space to share feelings-** talk how their brother or sister condition can be hard for them as well as for you. Respect their anger, anointment, anxiousness about it. Tell them that you are sorry for the lack of time and capacity for them.

• **Say thank you**- if you need your other children to help their sibling with LD in homework ask them for help. Do not expect them to do it. Thank them for doing that.

• **Show appreciation for their achievement –** sometimes you are so involved in supporting your child with LD that you forget to show appreciation for achievement of your other children. Remind your self to do it because every child no matter of level of capacities and maturity needs parents to praise him.

• **Show appreciation for their unique and important existence-** tell your children how happy and blessed you are for having them in your life.

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http:// www.understood.org/en/learning-attention-issues/understanding-childs-challenges/talking-with-your-child/how-to-talk-to-your-child-about-learning-and-attention-issues

Some more suggestions for you to check:

Advice for Parents of Kids With Learning Disabilities | Real Parents ...
https://www.youtube.com/watch?v=5UtUVI4xFkQ

5. Parenting children with ADHD and oppositional disorders

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Having child with attention deficit/hyperactivity disorder (ADHD)

ADHD is characterized by triad of symptoms (hyperactivity, inattention and / or impulsivity) that cause functional impairment in a child's social, educational and relational roles. Those impairments bring many challenges to children with ADHD and their parents in day to day family life, as well as in learning and social situations in school and with peers.

The challenges in family start when a child, because of his/her impairments, neglects chores and schoolwork, ignores family schedules, behave inappropriate in the given context and insensitive to social expectations. Parenting children with ADHD is a big challenge, especially when dealing with a child's noncompliance and oppositional behavior. Staying calm and positive in crisis situations is one among crucial recommendations for parents.

School is also very challenging place for child with deficits in abilities to sit still, concentrate, follow instructions, pay attention and listen quietly. Parents could help their children to cope these deficits by equipping child with learning strategies and communicating with teachers about how their child with ADHD learns best.

Inability to follow rules, inattention, impulsivity and lack of emotional regulation contribute to children with ADHD peer problems. They are often seen as lacking appropriate social skills, aggressive and hostile that make them unpopular in peer context. Children with ADHD have problems to establish and maintain close friendship, that is important protective factor for experience of peer rejection and bullying. Parents could help their children with ADHD to improve his/her interaction with peers.

In this chapter parents could find many useful strategies for coping with challenges of having child with ADHD.

Glossary

ADHD – attention deficit/hyperactivity disorder

Attention – act of applying our thoughts to something or someone; selective narrowing or focusing of consciousness and receptivity

Cognitive inhibition – ability to tune out stimuli that are irrelevant for the task at hand or mind's current state

Emotional regulation – capacity to adjust our emotional reaction to any given situation, so our emotional reactions are socially acceptable and context appropriate.

Executive functions – set of cognitive processes that are necessary for the cognitive control of our behavior. Based on executive functions we select and monitor our behaviors that facilitate the attainment of chosen goals. It includes basic cognitive processes such as attention control, cognitive inhibition, inhibitory control, working memory and cognitive flexibility.

Hyperactivity – higher than usual level of activity

Impulsivity – acting on impulse, without thinking before

Inhibitory control – capacity to inhibit our impulses and natural, habitual or dominant behavioral response on some situation in order to select more appropriate behavior that is consistent with completing our goals. Self-control is important aspect of inhibitory control.

Self-concept – collection of believes about oneself, presents the answer to "Who am I?"

Self-esteem – positive or negative evaluation of self; confidence and satisfaction with oneself

Working memory – capacity for temporarily holding information available for reasoning, the guidance of decision making and behavior.

Attention Deficit/Hyperactivity Disorder (ADHD)

Attention-deficit/hyperactivity disorder (ADHD) is a common and well recognized neurodevelopmental disorder that affects millions of children and often continues into adulthood. ADHD is characterized by triad of symptoms (hyperactivity, inattention and / or impulsivity) that cause functional impairment in a child's social, educational and relational roles, as well as impairment of self-concept and self-esteem (Barkley, 1990). ADHD severity may fluctuate somewhat across settings and time of day, and as a consequence of various factors in the situation, such as the schedule of the consequences for behavior, novelty, adult supervision, and / or the demands placed on them (Barkley, 2015). Not every child shows all of the associated or even core characteristics. Symptoms sometimes lessen with age. However, some people never completely outgrow their ADHD symptoms. But they can learn strategies to be successful.

The prevalence of ADHD in children appears to be on average between 5 and 7%, whereas in adults it ranges from 3 to 5% (Barkley, 2015). Among children, the gender ratio is approximately 3:1, with boys more likely to have the disorder than girls (Barkley & Murphy, 2006).

Major Characteristics

Inattention

A child who shows a pattern of inattention may (DSM V; American Psychiatric Association, 2013):

• Often fails to give close attention to details or makes careless mistakes in schoolwork, or during other activities (e.g., overlooks or misses details, work is inaccurate).

• Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).

• Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).

• Often does not follow through on instructions and fails to finish schoolwork, chores, or duties (e.g., starts tasks but quickly loses focus and is easily sidetracked).

• Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).

• Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

• Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).

• Is often easily distracted by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts).

• Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

Hyperactivity and impulsivity

A child who shows a pattern of hyperactive and impulsive symptoms may (DSM V; American Psychiatric Association, 2013; Barkley, 2015):

• Fidget with or tap his or her hands or feet, or squirm in the seat

• Often leaves seat in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, or in other situations that require remaining in place).

• Often runs about or climbs in situations where it is inappropriate.

• Often unable to play or engage in leisure activities quietly.

• Is often "on the go," acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).

• Often talks excessively.

• Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).

• Often has difficulty waiting his or her turn (e.g., while waiting in line).

• Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities);

• May start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

• Be unable to stop and think before acting.

• Respond quickly to situations, without waiting for instructions to be completed resulting in impulsive error.

• Fail to consider the potentially negative, destructive or even dangerous consequences that may be associate with particular situation or behavior.

• May carelessly damage or destroy others' property considerably more frequently than do children without ADHD.

• Have trouble to resist distraction while concentrating on tasks.

• Have difficulty to continue to pursue a task or goal despite getting negative feedback and without responding to indicated errors.

• Have difficulty to inhibit immediate reaction to an event as the situation may demand.

• Situation and games that involve sharing, cooperation, and restraint with peers are particularly problematic for these impulsive children.

• Verbally, often say thinks indiscreetly, without regard for feelings of others or for the social consequences for themselves.

Besides those three most common areas of difficulty associated with ADHD, Barkley and Murphy (2006) emphasized that persons with ADHD, particularly subgroup with impulsive behavior, may also have difficulties in the following area of psychological functioning:

• *Working memory, or remembering to do things.* Working memory refers to the capacity to remember information that will be used to guide one's actions either now or at a late time. It is essential for remembering to do thinks in near future. Persons with ADHD can often be described as forgetful around doing things, disorganized in their thinking and other activities as they often lose track of the goal of their activities. They also have problems with time management, thus they are often late for appointments and deadlines.

• *Delayed development of internal language (the mind's voice) and rule following.* An internal language is the private voice inside our mind that we use when talk to ourselves, contemplate, and direct and command our own behavior. Children with ADHD are significantly delayed in the development of internal language which has the effect on their self-regulation, their ability to follow through on roles and instructions; to read and follow directions carefully; to follow through their own plans, rules and "do-lists"; and even to act with legal and moral principles in mind.

• *Difficulties with emotional regulation, motivation and arousal.* Children with ADHD often have problems inhibiting their emotional reactions to events as well as to others. They show to others that they are angry, frustrated, upset or in some other mood much more often than would typical child do. They seem less able to keep their emotions to themselves, and even to moderate them by conscious, effortful, executive self-regulation as others might do. Children with ADHD often have difficulty with emotional self-regulation which represent a conscious, "top-down" and effortful (executive) moderation of the initial emotional reaction. Emotional dysregulation can be seen in three domains from temper control, affective lability and emotional over reactivity (Vidal et al., 2014). Reports estimates, prevalence of between 24% and 50% children with ADHD has emotional dysregulation (Biederman et al., 2012; Aili et al. 2015). Children with ADHD has been described as emotionally explosive, easily frustrated, and having low frustration tolerance, with frequent temper outbursts and mood lability. They are seen to be easily angry, hot-tempered, sensitive thus easily annoyed and reacts to the slightest comments (Barkley, 2010; Aili et al. 2015). Deficit in emotional inhibition and in emotional self-regulation could negatively contribute in conflict situation with parents, peers, and teachers, where children with ADHD mostly express impatient, anger, low tolerance on frustration, overreact emotionality and higher level of excitement than is expected from same age typical child.

Coupled with this problem of emotional regulation is the difficulties they have in generating intrinsic motivation for tasks that have no immediate payoff, stimulation, or interest to them. In such situations, they show lack of willpower or self-discipline. Also, related to these difficulties with regulating emotions and motivations that of regulating their general level of arousal to meet situational demands. Children with ADHD find it difficult to activate or arouse themselves to initiate work that must be done and often complain of being unable to stay alert in boring situations.

• *Diminished problem –solving ability, ingenuity and flexibility in pursuing long-term goals.* Oftentimes when we are faced with *problems that are obstacles to the goal's* attainment we must be capable of quickly generation a variety of options, considering their respective outcomes, and selecting among them one that seems most likely to surmount the obstacle, so we can continue toward our goal. Persons with ADHD find such hurdles to their goals to be more difficult to surmount; they often give up their goals in the face of obstacles and do not take the time to think through other options that could help them succeed toward their goal. Thus, they may appear as less flexible in approaching problem situations and more likely to respond automatically or on impulse.

• *Greater than normal variability in their task or work performance.* Very often persons with ADHD show substantial variability across time in quality, quantity, and even speed of their work. They fail to maintain a relatively even pattern of productivity and accuracy in their work from moment to moment and day to day. Such variability is often confusing to others, as person with ADHD can complete his/her task quickly and correctly, whereas in other times his/her task are performed poorly, inaccurately, and quite erratically. This variability in work performance researchers related to the problems with intrinsic motivation, such the person with ADHD is more dependent to the level of interest, rewards, or other consequences in a task itself for determining how long they can sustain interest. If the task is very interesting or if an immediate consequence is associated with getting it done, they often can sustain their effort for a longer time and with less variability.

There are three subtypes of ADHD:

• **Predominantly inattentive.** The majority of symptoms fall under inattention.

• **Predominantly hyperactive-impulsive.** The majority of symptoms are hyperactive and impulsive.

• **Combined.** The most common type, this is a mix of inattentive symptoms and hyperactive-impulsive symptoms.

Etiology of ADHD

ADHD is a highly heritable disorder. Barkley (2017) emphasize the contribution of genetics to ADHD as substantial in explaining most of the variation among people in ADHD traits. Barkley (2017) has explained several ways in which genes affect ADHD. The first is by inheritance. The child inherits the genes for ADHD from their parents. Scientists have identified about 25-45 genes related to ADHD symptoms based on genome-wide scans. So, the disorder is polygenic, meaning multiple genes contribute to the disorder with each likely contributing a small risk - but a combination of them creates increasing risk for disorder. The more risk genes you have the greater the risk for expressing the phenotype of the disorder. Parents with ADHD have a better than 50% chance of having a child with ADHD, and about 25% of children with ADHD have parents who meet the formal diagnostic criteria for ADHD. Twin studies have placed the heritability of ADHD in the range of 80%.

Barkley (2017) explain that the second way genetics can affect expression of the disorder is through the occurrence of new mutations in the genes of the child that are not present in the genome of the parents. Researchers think this may account for at least 10% of ADHD, especially if they are new cases arising in a family that has no increased risk among the relatives. Barkley (2017) also describe other genetic influence on ADHD, such as gene by gene interaction; gene by environment interaction; epigenetics effects, etc.

The remaining cases of ADHD are not genetic, but likely arise from neurologically compromising events: early brain injuries or maldevelopment alone (no genetic effects) when some event or agent damages the development of certain brain areas related to ADHD traits, such as the prefrontal cortex, basal ganglia, and cerebellum (Barkley, 2017). Many of these risks occur during pregnancy, such as significant prematurity of delivery, significantly low birth weight, exposure to multiple infections, maternal alcohol use, etc. These likely explain about 15-25% of ADHD cases in total (Barkley, 2017).

Other biohazards occur after birth, such as head trauma, tumors, strokes, lead poisoning during the first few years of life combined, probably account for 5-10% of ADHD or less.

So, all of this is to say that most of the causes of ADHD are genetic or neurological (or both). Yet certain events or agents in the environment can also cause ADHD or interact with ADHD risk genes to lead to its occurrence. Even so, Barkley (2017) highlights that there no evidence that social factors by themselves, such as parenting, exposure to computers or video games, quality of education, peer influences, etc. contributes directly to the risk for ADHD.

Child with ADHD in the family

Children with ADHD and their families face many challenges. The challenges start when a child neglects chores and schoolwork, ignores family schedules, and generally fails to live up to his/her parents' expectations. In response, Mom and Dad discipline – setting ever more stringent limits on his/her behavior, and increasingly severe penalties for failing to toe the line. The child grows angry, defiant, and alienated. This contest of wills pits child against parent, and even parent against parent. It can last for years, and the whole family suffers.

Child with ADHD comes across as a child with a bad attitude rather than what he/she is: A child with a neurological problem, described earlier in this text. For children with ADHD, the inability to focus, attend to lessons, listen and obey instructions, and the presence of impulsive behavior often impact their functioning and interaction with others (Aili et al. 2015). Because of their problems with inhibition child with ADHD often excessively respond to things when he/she is stressed. This causes parent-child communication and interaction to deteriorate quickly as many times child with ADHD responded by answering back to parents instead of taking time to assess the task or requests from them and to come to a reasonable response. Because of their inability to regulate their behaviors and emotions, children with ADHD are seen as being disruptive and annoying. Their behaviors are highly intense, unmodulated and often inappropriate in the given context and insensitive to social expectations (Aili et al., 2015). These difficulties impair their academic and social functioning, as well as relationship with parents, teachers and peers.

Parenting children with ADHD is a big challenge to many parents. It is stressful dealing with a child's noncompliance and oppositional behavior. Mothers are especially vulnerable. Mothers of children with ADHD have higher rates of depression and anxiety. They experience higher levels of daily child-rearing stress. As their child has more and more behavior problems, it can lead to more stress.

Parents frequently misinterpret their child's behavior and intentions, and are often frustrated as "correcting their child's behaviors" is every so often associated with more oppositional behaviors from the child. Some parents are not aware of their child having a disorder, or even aware what behaviors are related to the disorder. The problematic parent child interactions are often ongoing and repetitive, characterized by parents requesting for compliance, followed by the child's refusal to

comply. This often results in either escalation of parents control and demanding or in other instances the parents give up. Despite this, there is still a presence of frustration and anger in the environment. Many are unaware that the parent child interactions negatively reinforce each other in ways that increase the probability and severity of the child's problematic behavior(s) and the deterioration of the parent child relationship.

It is well known that parents' behavior and interaction with their children creates an emotional climate for the parent–child relationship. Parenting practices and behaviors are directly linked to children's emotional, behavioral regulation, social and interpersonal competence (Aili et al. 2015). Researches show that parents of children with ADHD tend to be more controlling, disapproving and rejecting of their children, use more verbal direction, repeated commands, added with more verbal reprimands and correction of their children than parents of typical children (Aili et al. 2015).

The parents' expectations and their beliefs, perceptions, and attribution about the child affect their behavior toward the child. Thus, if the parents feel their child is exhausting for them, it creates more tension in their relationship. Some parents may initially be overwhelmed with guilt feelings and blamed themselves for the children's misbehaviors however when the situation deteriorates, and things worsened, feelings of hopelessness and helplessness creep in. In other parents, they may have difficulty accepting the fact that their child is suffering from a disorder, given the stigma attached to the illness.

Like any parents, parents of ADHD children may have their own difficulties. Presence of parental stress, marital disharmony, high expressed emotions etc. affects parental functioning, family involvement and the parent child interaction. Without doubts, problematic parent child relationships add to the parenting distress. As was described in etiology paragraph, ADHD is highly heritable disorder, so parents of children with ADHD are more likely to have ADHD themselves. Presence of parental ADHD symptoms significantly impairs parents' parenting of their children, affecting the parental and child interactions and relationship.

In most parents, their ADHD symptoms have not been assessed. The symptoms of inattentiveness and impulsivity are likely to cause adults with ADHD to engage in harsh or lax parenting behaviors when dealing with their child's problems (Chronis-Tuscano et al, 2008). It is more difficult for parents to refrain themselves during discipline encounters therefore they are likely to use more negative and coercive methods. As the presence of ADHD results in difficulties with self-regulating, this may effect parents ability to think through about long term gains (Chronis-Tuscano et al, 2008). The short attention span and impulsivity may make it difficult for a parent to stay focused or be consistent in monitoring or carrying out rules (Harvey et al., 2003). Harvey and coworkers reported (2003) that mothers with ADHD tended to use more repetitions during attempts to get their child to comply. This often results in arguments because repeated and angry requests from mothers are often ignored.

Aili et al. (2015) have presented evidence of reciprocal pathways between child disruptive behavior and parent–child interaction difficulties. Being in a chaotic, harsh, unsupportive or unresponsive family environment exacerbate inattentive, impulsive, and hyperactive behaviors of children with ADHD.

The struggle ends only when everybody works together to create an environment in which behavior patterns are allowed and encouraged to change. Each family member must be educated about ADHD, and must learn to negotiate solutions and change his expectations of everyone else.

For the beginning, parents could foster a sense of "connectedness" within the family through relax family dinners, bedtime stories, and shared chores. Since struggle involve everyone in the family, all should be included in finding solutions. It is recommended to focus on one problem at a time – homework, mornings, and so on, and use brainstorm ways to correct the problem. It is very important to **separate the person from the problem.** Kids need to know that their parents love them no matter what. Most parents realize this, but sometimes, in the heat of battle, forget.

Fortunately, while there are many challenges that come with raising children with ADHD, there are also effective strategies and rewards.

Parenting strategies for children with ADHD

Here you can find useful strategies for parenting children with ADHD that have been selected and formulated based on tips downloaded from several web pages: HelpGuide.org; Focus on the Family and Child development institute.

Stay calm and positive. More than any other recommendation, this one is crucial in maintaining relative calm atmosphere in the family. Having a child with ADHD can be very draining to a parent. You may start to feel like no matter what you do, you don't have any effect on your child's behavior. **In situation of crises, remaining calm is substantial. Utilize your relaxation, stress management techniques and /or stress inoculation in order to ignore some behaviors of your child with ADHD. Calm create the environment most conductive to maintain relationships and keeping child under control. Filter allow the parents to focus on critical behaviors while ignoring the annoying ones** (Flick, 2010). **When negative attention is given, everyone becomes more tensed. As behavior escalates, relationships are stressed, and the situation sometimes culminates in a violent interchange** (Flick, 2010).

When you start feeling down, either about yourself or about your child, it's important that you try your best to stay positive. To do this, Melinda Smith and Jeanne Segal, contributors to HelpGuide.org, recommend trying to keep things in perspective, not letting the little things bother you, and making a habit of positive talk about your child. Just simply taking a step back, breathing, and reminding yourself that your child is valuable can make a big difference in how your days go and how your child feels about him or herself. Staying calm and focus you are more likely to be able to connect with your child, helping him or her to be calm and focused as well.

HelpGuide.org also recommend:

"Keep things in perspective. Remember that your child's behavior is related to a disorder. Most of the time it is not intentional.

Believe in your child. Think about or make a written list of everything that is positive, valuable, and unique about your child. Trust that your child can learn, change, mature, and succeed. Make thinking about this trust a daily task as you brush your teeth or make your coffee."

The ADHD child needs structure and consistency. (downloaded from Focus on the Family web site) A predictable routine every day, with specific times for meals, chores, homework, bathing, and bedtime, creates a stable framework for his/her life. Structure helps reduce disorganization and distractibility. Explain any changes in routine in advance. Make sure your child understands the changes. For the uninteresting tasks such as homework, prepare certain privileges only available to the child after they've successfully completed their assignments. The ADHD child most often wants to do what is right. External structure helps move him in the right direction.

House rules and expectations for behavior should be explicit, understandable, and *achievable*. The home structure should be free of pressure, free of using threats or unreasonable deadlines and punishments that contribute to hostility, fear or drama.

Give instructions simply and clearly; avoid giving a chain of directions. (downloaded from Focus on the Family) A half hour after making a seemingly simple statement such as "Put the LEGOs away, let the dog out, and get your coat," you may find the ADHD child playing with another toy he spotted while putting away the LEGOs. The dog and the coat will have been long forgotten. If you have more than one thing you want him/her to do, tell him one step at a time.

Don't sweat the small stuff and be willing to make some compromises. One chore left undone isn't a big deal when your child has completed two others plus the day's homework. If you are a perfectionist, you will not only be constantly dissatisfied but also create impossible expectations for your child with ADHD (HelpGuide.org).

Enforce rules and limits consistently and predictably, with consequences appropriate for the violation. (downloaded from Focus on the Family web site) Discus with the child what the consequences should be if he/she breaks a rule. This helps kids create commitments that they can actually own. In addition, create and consistently enforce positive consequences for positive behaviors and negative consequences for negative behaviors. The punishment for breaking rules should be fair, quick and consistent.

For example, if he charges going into a busy street on his being warned not to do so, bike-riding privileges should be suspended for a day. If he knowingly mistreats a toy and it falls apart, don't repair or replace it right away. If he has become too excited or aggressive playing with other children, give him a time-out in an uninteresting spot (Focus on the Family).

Focus on the family recommends that the child with ADHD may not seem to "get the picture," and he/she may actually repeat the behavior for which you just punished him. *It is important to make him suffer consistent consequences each time but not to yield to extremes: either giving up, which forfeits your right to be in charge, or reacting with increasingly harsh punishments.*

As with all children, pick your battles carefully. Behaviors that put him or others at risk or are overtly destructive need your decisive response. But if you go to the mat with him over every minor annoyance, you'll be exhausted — and thoroughly depressed — every day.

Set up homework routine. (downloaded from Child development institute web page) Pick a regular place for doing homework. This place should be away from distractions such as other people, television and video games. Break homework time into small parts and have breaks. For example, give your child a snack after school and then let him play for a few minutes. then start homework time. Stop frequently for short "fun breaks" that allow your child to do something enjoyable. Give your child lots of encouragement, but let your child do the school work.

Offer praise and encouragement. (downloaded from Focus on the Family web site) The child with ADHD needs to know he is loved and accepted as an important member of the family, especially because his disruptive behavior, difficulties with schoolwork, and lack of success in other areas such as games and sports will generate negative feedback from several directions. He needs to know that you and others are on his team and always will be.

Tell your child what you want rather than what you don't want. Reward your child regularly for any good behavior–even little things such as getting dressed and closing doors quietly. Children with ADHD often spend most of their day being told what they are doing wrong. They need to be praised for good behavior.

When he/she does what he's/she's told, accomplishes a task, plays well with another child, or makes progress at school, praise him/her. A special time of ten or fifteen minutes every day with one or both parents can allow some positive attention to be focused on him/her regularly.

When he/she messes up, keep your comments constructive. For example, "Let's set an extra alarm to help you get up on time" is more helpful than "Why can't you ever get up on time?"

Expect rule-breaking, and don't take it personally. Children occasionally break the rules set by parents. When child with ADHD break the rule, parents should peacefully and respectfully comment what had happened and what would be consequence of that, without jelling and taking it personally.

Child with ADHD in school

School is very challenging place for child with problems with attention, inhibitory control, motivation, working memory, inability to stay still for a long time that are all characteristics of ADHD. The process of learning brings tasks that children with ADHD find the most difficult, such as concentrating on tasks that are very often not interesting to them, listening quietly without making comments, siting still all day long. Child with ADHD would like to learn and behave in school like other typical peers and to meet school expectations, but their neurological deficits do not allow that, and this make him/her highly frustrated. Child with ADHD, not because of unwillingness, but because of neurodevelopmental deficits, cannot for example maintain work activity for long time, complete complex tasks accurately and on time without some necessary accommodations that will rise his/her chance to realize success in school.

Parents could help their children to cope these deficits and meet challenges school create by equipping child with learning strategies for the classroom and communicating with teachers about how their child with ADHD learns best. Effective collaboration between parents and teachers could help child with ADHD to find his/her feet in the classroom and work effectively through the challenges of the school day.

Tips for collaborating with teacher (based on HelpGuide.org)

As a parent, you are advocate for your child and it is vital that you inform teachers about your child's needs for school adaptations, as well as to listen what teachers and other school officials have to say. Make communication with your child's school calm, positive, constructive and productive. You can plan to speak with a teacher or counselor on at least a monthly basis. The success of the child at school is a common goal, so listen carefully to what teacher has to say, even if it is sometimes hard to hear. Together with teacher, write down specific and realistic goals and talk about how they can be reached. Share information that can lead to better understanding of your child's hardships. Share with your child's teacher what tactics work well—and which don't—for your child at home. Ask if your child is having any problems in school, including on the playground. Find out if your child can get any special services to help with learning.

Children with ADHD need structure and clear expectations in order to keep their symptoms in check. As a parent, you can help by developing a behavior plan for your child—and sticking to it. Whatever type of behavior plan you put in place, create it in close collaboration with your child's teacher and your child. Create a plan that incorporates small rewards for small victories and larger rewards for bigger accomplishments.

Tips for managing ADHD symptoms at school (based on HelpGuide.org)

A child with ADHD exhibits a range of symptoms (described at the beginning of this chapter) that make school work more difficult. There are a variety of fairly straightforward approaches you and your child's teacher can take to put your child on the road to school success.

Managing distractibility

• Seat the child with ADHD away from doors and windows.

• Alternate seated activities with those that allow the child to move his/her body around the room. Whenever possible, incorporate physical movement into lessons.

• Write important information down where the child can easily read and reference it. Remind the child where the information can be found.

• Divide big assignments into smaller ones, and allow frequent breaks.

Reducing interrupting

• Develop a "secret language" with the child with ADHD. You can use discreet gestures or words you have previously agreed upon to let the child know they are interrupting.

• Praise the child for interruption-free conversations.

Managing impulsivity

• **Make sure a written behavior plan is near the student.** You can even tape it to the wall or the child's desk.

• **Give consequences immediately following misbehavior.** Be specific in your explanation, making sure the child knows how they misbehaved.

• **Recognize good behavior out loud.** Be specific in your praise, making sure the child knows what they did right.

• **Write the schedule for the day on the board** or on a piece of paper and cross off each item as it is completed. Children with impulse problems may gain a sense of control and feel calmer when they know what to expect.

Managing hyperactivity

• **Ask children with ADHD to run an errand** or do a task for you, even if it just means walking across the room to sharpen pencils or put dishes away.

• **Encourage a child with ADHD to play a sport**—or at least run around before and after school—and make sure the child never misses recess or P.E.

• **Provide a stress ball**, small toy, or other object for the child to squeeze or play with discreetly at his/her seat.

• **Limit screen time** in favor of time for movement.

Dealing with trouble following directions

• Try being extremely brief when giving directions, allowing the child to do one step and then come back to find out what they should do next.

• If the child gets off track, give a calm reminder, redirecting in a calm but firm voice.

• Whenever possible, write directions down in a bold marker or in colored chalk on a blackboard.

Tips for mastering homework (based on HelpGuide.org)

Homework is a golden opportunity for parents to support development of child's organizational and study skills necessary for success at school.

• Establish a homework folder for finished homework and organize loose papers by color coding folders and showing the child how to file appropriately.

• Help your child organize his or her belongings on a daily basis, including backpack, folders, and even pockets.

• If possible, keep an extra set of textbooks and other materials at home.

• Help your child learn to make and use checklists, crossing items off as they are accomplished.

• Pick a specific time and place for homework that is as free as possible of clutter, pets, and television.

• Allow the child breaks as often as every ten to twenty minutes.

• Teach a better understanding of the passage of time: use an analog clock and timers to monitor homework efficiency.

• Set up a homework procedure at school: establish a place where the student can easily find his or her finished homework and pick a consistent time to hand in work to the teacher.

Child with ADHD in peer interactions

Like any other child, child with ADHD like to spend time playing with peers. Moreover, interaction with peers is essential for a healthy social and cognitive development of the child and is one of the first relationships in which children learn and master the important social skills necessary for effective functioning throughout their lives. However, characteristics of ADHD (explained in the beginning of this chapter) such as impulsivity, problems with emotional regulation, inattention and poor executive functioning could contribute to a social failure of children with ADHD. Hoza (2007) estimated that between 50 to 80% of children with ADHD can be labeled as rejected by their peers. Researchers found that about 50% of children with ADHD fail to establish and maintain close friendship, friendships are less stable, and there are more conflicts than those found in typical peers. The peer rejection of children with ADHD is very stable over time, and is associated with non-compliance with the rules during their activities, inattention, frequent complaints, and grumbling that interfere with activity (Mrug et al., 2007).

Researchers suggested that there are subtype differences in the specific problematic social behaviors displayed by children with ADHD. A comparison of children with ADHD Combined type (ADHD-C), ADHD Inattentive type (ADHD-I), and comparison children suggests that their specific social behaviors differ considerably. Specifically, while peers are more likely to actively reject children with ADHD-C and to rate them as more likely to start fights, children with ADHD-I are more likely to be socially isolated, and to be rated by peers as shy. While inattentive symptoms contribute to greater difficulty attending and actively participating in social interactions, hyperactivity/impulsivity symptoms contribute to more aggressive and overtly negative social behaviors.

Gardner and Gerdes (2013) categorized social skills deficit experienced by youth with ADHD in three board domains: a) disruptive/inappropriate social behaviors, b) sociocognitive and social problem-solving deficits, and c) emotion regulation difficulties. Disruptive/inappropriate social behavior includes impulsivity, intrusiveness, hostility, lack of appropriate social skills, such as sharing, cooperation, and turn taking that are often seen in children and youth with ADHD.

Sociocognitive and social problem-solving deficits refer to poor attention of children with ADHD in social interactions that may lead to misattributions about the behavior and intentions of

peers (Sibley et al., 2010). Moreover, poor attention to social feedback may lead to inaccurate interpretations of social success and failure in children and adolescents with ADHD. A large body of research suggests that children with ADHD tend to overestimate their abilities and performance, as compared to actual performance measures or adult ratings. This overestimation of competency, termed a positive illusory bias, may play a role in the social difficulties of children with ADHD, especially if this bias contributes to a lack of awareness regarding areas in need of improvement (McQuade & Hoza, 2008). The inaccurate self-views of many children with ADHD may be crucial to understanding their continued failure to change their aversive or annoying behaviors, even after receiving negative social feedback from peers, parents, and teachers (McQuad & Hoza, 2008).

An additional area of social impairment in youth with ADHD is inadequate social problem-solving and perspective-taking skills. Sibley and colleagues (2010) found that adolescents had difficulty generating appropriate and effective responses to hypothetical peer interaction situations and performed poorly on tasks that assessed understanding of cause and effect in social situations. Research also found that children with ADHD generated more hostile and aggressive responses to hypothetical peer provocation scenarios than did typically developing children. Furthermore, children with ADHD tend to have poor social perspective taking skills and demonstrate less empathy toward peers (Barkley, 2006). Barkley (2006) hypothesized that poor inhibitory control, may be related to difficulty in inhibiting one's own responses long enough to consider and understand another child's perspective.

Impulsivity and emotion regulation difficulties also contribute to problematic peer relationships in youth with ADHD. Specific examples of emotional impairment include excessive expression of negative emotions, decreased tolerance for frustration, and reduced empathy (Barkley 2006). In summary, children and adolescents with ADHD experience significant peer relationship difficulties and social skills impairment that contribute to peer rejection, internalizing problems, school dropout, and substance abuse. Furthermore, many of the negative outcomes of impaired social functioning persist into adulthood. However, previous research also suggests that the presence of at least one mutual friendship may serve as a protective factor against negative peer outcomes, such as peer victimization.

Many researchers reported ADHD as a risk factor for bullying (Žic Ralić et al., 2016). Researches emphasize that children with ADHD are more likely to engage in bullying, either as being victims or being perpetrators of bullying in comparison with their classmates. Many characteristics of children with ADHD can affect their engagement in bullying, such as: insufficient behavioral inhibition which aggravates self-regulation and organization of future behavior; peer rejection; lack of interest in others; lack of interpersonal empathy, consideration of other pupils' needs, emotions and views; low frustration tolerance, verbal and physical aggression; focus on instant need fulfillment; difficulties in controlling their own emotions which interfere with the activity the children with ADHD are involved with; difficulties in processing social situations which cause misinterpretation and consequently, in unclear, provocative situations they attribute malevolence to peers and respond aggressively.

Since, peer relationship difficulties are significant impairment for majority of children and youth with ADHD, many peer functioning interventions have been developed, including traditional social skills training, social skills training with parent generalization, and social skills training with a dyadic friendship component. Interventions involving parent generalization or dyadic friendship components have resulted in greater overall improvement in participating children than programs

without these components. While effective treatment protocols for behavior management in home and classroom contexts are well established, effective peer functioning interventions require additional investigation.

To help their children with ADHD in peer relations parents could support child's inviting peers to their home, and discretely supervise their play. Here you can find some suggestions how to rise child with ADHD competences for social interaction with peers prepared by Croatian team of the EBE EUSMOSI project (Žic Ralić et al. 2017).

• Reinforce positive patterns of social interactions between your child with ADHD and their peers and teach him/her how to respond appropriately in different social situations.

• In team games encourage your child with ADHD to use cooperative behavior, such as: helping a team member; taking somebody else's opinion into account; listening when a team member has something to say; encouraging when peer encounter difficulties; avoiding attacking a team member; doing one's best for the common cause; agreeing how to achieve an objective; equality among team members; respecting differences.

• Encourage your child with ADHD to avoid non-cooperative behavior such as e.g.: arguing, imposing one's own opinion; underestimating others; forcing their opinion upon others; isolating or rejecting a peer from other peers.

• Talk with your child with ADHD and help him/her to interpret different ways in which children communicate, focusing on their facial expressions, tone of their voice, signs, gestures and intentions.

• Teach your child to recognize emotions on the faces of other children (e.g., some pupils should imitate some emotions, and the others should recognize what it is all about).

• Encourage making connections between particular situations and emotions (e.g., How does Marko feel when he gets an A?; How does Marko feel when he falls down on the school playground?; How does Ana feel when everybody listens to her while she recounts something she experienced?; How does Ana feel when her friends fail to invite her to do something together with them?, etc.).

• Teach your child how to make a connection between the tone of their voice, gestures, emotions and the situation

• Teach your child to recognize intentions in the behavior of others, particularly in ambiguous situations, for instance when somebody pushes a pupil in the crowded school hall during recess – was it done deliberately or accidentally

• Discus with your child's teacher about peer relations of your child with ADHD in school and his/her peer acceptance. Share with the teacher efforts you have made to rise your child with ADHD peer functioning.

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6. Parenting children with emotional disorders

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Chapter summary

In this part we are talking about ***Parenting children with emotional disorders.*** We introduce the basic concepts about emotional disorders. Statistics are presented too. We are discussing

What is an Emotional Disorder?
What is a Disorder?
When the Emotional Disorder turns into a Disability?

We introduce the List of Emotional Disorders too. We as well present some strategies such as *Behavior Therapy for Children, Cognitive Therapy for children with Emotional Disorders, Interpersonal Therapy for Children with Emotional Disorders, Family Therapy.* To encourage for discussion we suggested a crossword puzzle and some questions. We also provided other useful information such as *Helpful Websites, Blogs, Family Voices, Center for Parent Information and Resources, Videos, Associations and Societies* and other information.

1. Glossary/Words to know/Definitions

„Technically speaking, there is no category in the **Diagnostic and Statistical Manual (DSM-V)** specifically called **emotional disorders**. The category is too broad and would include many different types of **disorder**. So, to get an accurate definition, emotional disorders need to be broken down into several smaller subsets. It is also necessary to understand what is meant by disorder in the first place". https://study.com/academy/lesson/what-is-an-emotional-disorder-definition-types.html

„Emotional and behavioral disorders (**EBD**; sometimes called **emotional disturbance** or **serious emotional disturbance**) refer to a disability classification used in educational settings that allows educational institutions to provide special education and related services to students that have poor social or academic adjustment that cannot be better explained by biological abnormalities or a developmental disability". https://en.wikipedia.org/wiki/Emotional_and_behavioral_disorders

„Emotional disorder is a mental disorder in which one's emotions are disturbed to a great extent. This disorder is not due to any abnormalities in the brain development or function. It is a psychological condition in which thoughts and emotions are not in the proper state. When the personality of an individual is exhibited by unduly emotional thinking and dramatic behavior, it is clearly an indication of overly emotional disorder". https://www.trivedieffect.com/inspiration-blog/overly-emotional-disorder/

„Some of the characteristics and behaviors seen in children who have an emotional disturbance include: **Hyperactivity** (short attention span, impulsiveness); **Aggression** or self-

injurious behavior (acting out, fighting); **Withdrawa**l (not interacting socially with others, excessive fear or anxiety); **Immaturity** (inappropriate crying, temper tantrums, poor coping skills); and **Learning difficulties** (academically performing below grade level)". http://www.parentcenterhub.org/emotionaldisturbance/#def

„The terminology used to classify mental health disorders like emotional disorders has developed and changed over many decades. Multiple usages are current and can be very confusing. 'Affect' is another term for 'mood', so one term often used is 'affective disorders' which simply refers to 'mood disorders'. Depression (also known as major depression or MD) is the most commonly occurring of the set of mood disorders known as affective disorders". http://www.open.edu/openlearn/health-sports-psychology/health/emotions-and-emotional-disorders/content-section-1.1

„**Mood**, like emotion, is an affective state or in layman's terms; 'a feeling'. Those in favour of a distinction between the terms 'mood' and 'emotion' suggest that emotion has a clear focus (i.e. its cause is self-evident), whereas mood is diffuse and can last for days, weeks, months, or even years".http://www.open.edu/openlearn/health-sports-psychology/health/emotions-and-emotional-disorders/content-section-1

2. You are not alone – Statistics related to children with special needs and their parents

"Below are 19 statistics that prove that these disorders touch more people than you might think"

61,500,000

The approximate number of Americans who experience a mental health disorder in a given year. That's one in four adults.

$100,000,000,000

The estimated economic cost of untreated mental illness in the U.S. This includes unemployment, unnecessary disability, substance abuse and more.

70 - 90%

The percentage of individuals with mental illness who saw improvement in their symptoms and quality of life after participating in some form of treatment.

800,000

The estimated number of people globally who die by suicide each year.

25%

The approximate amount of people with a mental illness who feel that others are compassionate or understanding toward those suffering from one of the disorders.

350,000,000

The number of people worldwide who are affected by depression.

79%

The percentage of all U.S. suicides committed by men.

40,000,000

The number of adults who suffer from anxiety disorders in the U.S.

30%

The number of college students who reported feeling depressed to the point where it negatively impacted their ability to function. Approximately 7.5 percent of college students also reported earlier this year that they seriously considered suicide in the last 12 months.

22

The (potentially underestimated) number of veterans who die by suicide each day, according to a 2013 report by researchers at the Department of Veterans Affairs.

10%

The percentage of children and adolescents whose mental and emotional disorders disrupt their day-to-day lives.

3,500,000

The number of Americans who suffer from schizophrenia. The disorder usually develops between ages 16 to 25.

60%

The percentage of adults who didn't receive mental health treatment in 2012.

6,100,000

The number of individuals in the U.S. who suffer from some form of bipolar disorder.

21%

The percentage of mothers polled in a recent BabyCenter survey who stated they have been diagnosed with postpartum depression. Approximately 40 percent of them did not seek medical treatment.

5,200,000

The estimated number of adults who suffer from post-traumatic stress disorder in a given year.

7

The number of people who die by suicide per hour in the Americas.

11%

The percentage of adolescents who have a depressive disorder before the age of 18.

90%

The percentage of people who die by suicide who also had a mental health disorder".

Material taken from:

https://www.huffingtonpost.com/2014/12/01/mental-illness-statistics_n_6193660.html

3. Theoretical section on the topic of our specific subject

„What is an Emotional Disorder?

Technically speaking, there is no category in the **Diagnostic and Statistical Manual (DSM-V)** specifically called **emotional disorders**. The category is too broad and would include many different types of **disorder**. So, to get an accurate definition, emotional disorders need to be broken down into several smaller subsets. It is also necessary to understand what is meant by disorder in the first place.

What is a Disorder?

When Kathy started studying to be a counselor, her professors told the class that they would have to read and understand the DSM-V in order to accurately diagnose. The teacher said that they

would have many opportunities to do this, but they needed to understand the basics of diagnosis first. Kathy learned that many of the diagnoses seemed to fit her, and others in the class made the same discovery. But, the professor told them that for something to reach the level of disorder it had to be **harmful to the individual or to others**. For example, Kathy was told, everybody is depressed from time to time, but **depression** becomes a disorder when it disrupts the individual's daily life to a significant extent. It makes them unable to function in the world. The job of the counselors was to use the DSM-V to determine if an individual's issues reached the level of disorder.

When Emotional Distress Becomes a Disorder

The class then learned that emotions, or rather the dysregulation (improper channeling) of emotions, can become a disorder. But, there are different types of emotional disorders. The instructor told Kathy and the rest of the class that emotional disorders are generally broken down into **mood disorders** and **anxiety disorders**. Within these two types are many other, more distinct types of disorder. But, they were told:

- Mood Disorders are characterized by a mood or emotions that are not appropriate to a given situation.
- Anxiety Disorders occur when an individual remains in a persistent state of anxiety for an extended period of time.

These two types of disorder are also broad categories that contain more specific disorders under their respective umbrellas".

Material taken from:

https://study.com/academy/lesson/what-is-an-emotional-disorder-definition-types.html

Moods, emotions and disorders

„Mood, like emotion, is an affective state or in layman's terms; 'a feeling'. Those in favour of a distinction between the terms 'mood' and 'emotion' suggest that emotion has a clear focus (i.e. its cause is self-evident), whereas mood is diffuse and can last for days, weeks, months, or even years.

Other researchers use the terms 'emotion' and 'mood' interchangeably. The basic disagreement seems to be about whether it is important to recognise that one state (emotion) is normally associated, by the person experiencing it, with a particular object or cause, and the other (mood) is often not. What difference might this make? Some evidence suggests that a particular 'mood' can affect our thoughts, perceptions and behaviours for prolonged periods – the so-called 'mood effect'.

There is evidence that when a mood or its source is brought to the attention of the person experiencing it, the mood effect can disappear (Schwarz, 1990). So it has been suggested that although moods (like emotions) can have identifiable sources, the effects of moods depend on the sources going unnoticed; and that a distinction between moods and emotions is therefore meaningful and even useful.

Certainly, it may help our understanding of some kinds of treatment for affective and anxiety disorders. For instance, mindfulness-based or cognitive therapy approaches may exert their effect by training people to become more aware of their moods, and of what is influencing or causing them.

Another common distinction found in the study of moods and emotions concerns states and traits. A trait is a relatively stable attribute of an individual, whereas a state is a temporary response to circumstances.

Take, for example, anxiety. A person shows state anxiety when something causes him or her to feel anxious temporarily. The anxiety then dissipates and the person feels 'normal' again. An example might be the anxiety that some people feel when heading to an appointment with the dentist, or waiting for an operation. However, in some people anxiety is a trait – they can simply be described as 'anxious people'. Trait anxiety has therefore been suggested to be a relatively stable characteristic of a person.

While traits may indeed be more stable, it does not mean that they are not malleable, at least to some extent, though perhaps they are harder to change".

Material taken from:

http://www.open.edu/openlearn/health-sports-psychology/health/emotions-and-emotional-disorders/content-section-1

LIST OF EMOTIONAL DISORDERS

„Emotional disorders list would typically cover various types of emotional disorders in various stages – from childhood to adulthood. Several such emotional disorders in children are broadly categorized into conduct disorders, emotional disturbances, personality disorders, anxiety disorders, and so on. Though the list of overly emotional disorders in children is endless, the following are the frequently exhibited disorders.

CONDUCT DISORDERS

Children suffering from conduct disorders are mostly diagnosed with anti-social behaviors, namely aggressiveness, throwing tantrums, stealing, lying, and hostility, destructive and manipulative attitude. Their noncompliance to rules and indifference towards others poses a great challenge to teachers, leading to frustration and annoyance.

AFFECTIVE DISORDERS

Emotional disorders list include improper eating habits, depression, and extreme stress; most of these lead to negative behavior in the individual's personality. In children, the most commonly encountered psychiatric emotional disorder is the change of mood. It includes depression and bipolar disorder.

PERSONALITY DISORDERS

The rigid and pervasive behavior pattern exhibited is totally different from the cultural expectations, and results in distress. The disorder may be schizotypal, showing uneasiness in close relationships or borderline, marked by uncertainty in interpersonal relationship or dependent, exhibiting a highly clinging attitude with the need to be cared for.

ANXIETY DISORDERS

The most prevalent types of emotional disorders in children are anxiety disorder. The suffering children exhibit fear, shyness and nervousness. It includes phobia, panic, obsessive-compulsive disorders, separation anxiety, and post-traumatic stress disorder.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Children exhibiting over activity and short span of attention are easily diverted and are unable to consolidate their schedules.

OPPOSITIONAL DEFIANT DISORDER

Children easily lose their temper and argue a lot with others. They are quickly irritated by others and express anger often.

PERVASIVE DEVELOPMENT DISORDER

Distortions in the thought process of a child and delay in development is caused when the brain is incapable of processing the information. It includes autism and Asperger's syndrome.

SCHIZOPHRENIA

Schizophrenia includes poor reasoning and judgment, hallucinations, delusions, lack of motivation and concentration".

Material taken from: https://www.trivedieffect.com/inspiration-blog/overly-emotional-disorder/

SIGNS OF EMOTIONAL DISORDERS IN CHILDREN

„When children exhibit overly emotional disorders symptoms over a considerably long period, it affects their educational performance to a great extent. This inability to learn something cannot be attributed to intellectual, sensory or health reasons. Children suffering from any kind of overly emotional disorder cannot develop or continue a good rapport with other fellow students and tutors. Even under absolutely ordinary situations, their moods and activities are unfitting, as they experience sadness and a mood swing most of the time. They cultivate a sense of phobia related to own or school matters.

Children suffering from overly emotional disorders are highly impulsive and exhibit violent conduct, both on self and others. They are always anxious and have very little attentiveness. They are not bothered about following rules in the classrooms and often disturb the on-going activities. Emotionally disordered children cannot adapt to any variations in the routine setup. Such kids scheme to accuse others and find it hard to work in groups. They suffer from low self-esteem, which makes them absentees from school mostly.

Their eating habits change leading to sudden weight gain or loss. Sleeping pattern is also erratic. Some children have excess energy to be spent on exhausting activities. Rapid mood swing from extreme joyous feeling to severe depression is a common feature.

The usual teaching methodology cannot be applied to children with overly emotional disorders. The special education approach must be re-designed to discourage the unruly activities and encourage the preferred behavior. The child must be diagnosed through professional clarifications by an expert psychologist".

Material taken from: https://www.trivedieffect.com/inspiration-blog/overly-emotional-disorder/

Behavior Therapy for Children

„Cognitive therapy involves minimizing anxiety, learning alternative ideas and learning that feelings and moods alter behavior. It helps the child to identify their inner thoughts and replace bad thoughts with positive productive thoughts. Applied behavior analysis analyzes behavior and teaches the child different ways to respond to situations in a positive way. It also rewards positive behavior and punishes negative behavior. Play therapy is exactly that for younger children it allows them to act out their issues through role playing or they can interact with common issues dolls and sensory objects.

Children with behavioral issues need to have some type of therapy that allows them to express themselves without consequences and then slowly build up their level of trust with the counselor. Once this is done the child can begin to learn the reasons for their behavior and what the trigger points are and how to deal with those issues once they arise.

Before starting any type of behavioral therapy the parent should closely watch the child and keep a diary of what is going on, consult a therapist and proceed from there. If there are substantial behaviors or emotional issues present the parents should find a licensed behavior therapist that deals with stress management strategies, relaxation training, teaches coping skills, and uses talk therapy. Treating the child with respect is the first step to getting the child help. The child should show some type of progress overtime and learn to deal with things by situation; they must learn to cope with difficult situations at home and at school. Behavioral Therapy for children with behavioral and emotional disorders require intensive behavioral therapy tools to help them to deal with outside pressures and triggers on a daily basis".

Material taken from:

http://www.kidsmentalhealth.org/behavioral-therapy-for-children-with-emotional-disorders/

Cognitive Therapy for children with Emotional Disorders

„Cognitive therapy is a scientifically proven method of treatment that works for younger patients as effectively as it does for adults in the treatment of the anxiety disorders as well as such disorders as conduct disorder, depression, and physical complaints that are not caused by an actual physical condition. **Cognitive therapy**is actually most often used in conjunction with behavioral therapy when used with children and most often is aimed at trying to break the circle of emotion – thought – behavior that is thought to cause most of the symptomology that the therapy is intended to ameliorate. The idea is that a person feels an emotion which leads to a thought that is uncomfortable which in turn leads to a behavior that makes the feeling better, but the feeling is then affected by the behavior so that it leads to another uncomfortable thought which leads to another and possibly even more inappropriate behavior which leads to another feeling and so on. Cognitive therapy is an attempt to change the thought into a more realistic and helpful one thus breaking the circle.

In treating children there are stressors that are not usually present for adults generally related to education. A child might have unrealistic goals that are reinforced by adults in his or her life: perfection as the only acceptable outcome is a primary one. When perfection is the only goal then failure will be the most usual experience for a child and failure is a very unhappy thing indeed. In order to avoid the bad feelings and thought engendered by failure the child acts out by being bad in some way and sometimes finds that he or she can be perfectly bad which feels like a success, and success leads to further acting out. Breaking the cycle by making trial and error an acceptable outcome, a success, takes the onus of failure away and can lead to a change in behavior by the redefinition of success.

With children and adolescents cognitive therapy is focused on breaking the circle at the thought phase. Having the child focus on the thought and bringing that step in the cycle come more under his or her control can help him or her to see the fallacies in the thoughts and thus repair his or her behavior to the reality of the situation rather than continue in the avoidance behaviors that are inappropriate. In hundreds if studies, cognitive therapy has been shown to be quite effective".

Material taken from: http://www.kidsmentalhealth.org/cognitive-therapy-for-children-with-behavioral-and-emotional-disorders/

Interpersonal Therapy for Children with Emotional Disorders

„Many children with behavioral and emotional problems do not realize that their actions are wrong, even after they have been punished for them.

Others, cannot control many of their actions, so they do not exactly get the full benefit of the disciplinary action that they have been given. These problems usually result in a very upset parent, and very confused child. However, it does not have to be this way for either of them. Turning to an interpersonal therapist may be the answer you are both looking for.

When you wish to choose an interpersonal therapist for your child, it is important to decide whether your child works better with males or females. If your child does not work well with male figures, it may be better to choose a therapist that is female or vise versa. Ensuring that your child is comfortable with the therapist they will be seeing is crucial to the success of the therapy.

The therapist your child sees will more than likely have the first few visits together as a family. However, after the initial few visits, they may just want a verbal update from you and then see your child alone. The key for this therapy is to ensure that the child is focused on the therapy.

Each session the therapist will try different methods of teaching your child how to deal with anger, frustration, or their emotions in general. After every appointment, your child will be expected to demonstrate these new skills and focus on them. These skills will gradually build on each other until they have complete behavioral or emotional control for themselves. At this point, the therapist will focus on maintaining these skills with your child.

It is important to be consistent with the appointments. Missing an appointment may cause your child to slip or regress slightly in their behaviors.

Do not think that because the behavior has not been obvious, that it means it has went away. It means that your child is learning how to get past that behavior. Once they have learned control of it, then they will understand discipline for that specific behavior. Keeping them focused on what is expected of them is important. Do not forget to praise your child on controlling themselves. They need to know that you see the changes they have made and that you are proud of how far they have come".

Material taken from: http://www.kidsmentalhealth.org/interpersonal-therapy-for-children-with-behavioral-and-emotional-disorders/

Family Therapy

„Almost a third of children born will have some type of disability by the time they are 18. For most families, the child is not the only one who will have to learn to live with a disability.

The whole family will be touched by the disability. **Therapy for the entire family will often be necessary to make sure that the child is able to integrate into the family life**. When the diagnoses first comes, the parents are often dealing with shock and disbelief, but as time goes on, they learn to adjust and accept the circumstances. Many of them would benefit from some type of family counseling. This is very important because they are going to play a big part in how the child with the disability will be able to adjust. As the primary caregivers the role they play is huge and special training is often necessary and very helpful.

For the family who has a child born with an obvious disability, the realization will come quickly that they will be walking a different road then they had planned in life. Therapists, Doctors and special equipment will often be part of their daily norm. The adjustment is often difficult and is

an on going process. Some families do not realize that their child has a disability until they are a little older. Autism, mental retardation and emotional illnesses do not show up during the first months of life. It is only after frustration and often denial that the parents are able to realize the child has some extra needs that they are unable to meet.

A child with a disability will often require around the clock care. They might need a special diet and help with toileting on a regular basis. It can also affect the family financially and that is just the beginning. **The biggest problem though is that the parents are not trained to deal with needs of the child** and often tend to over protect them. They do this out of love, but it is often detrimental to the child. Family therapy should involve not only the parents, but the siblings. They should not be forgotten in this equation. Often they will be asked to do some of the care and many of them will be the sole caregivers as adults for the person with the disability because they parents may not always be in a position to do it.

Family therapy should address feelings that everyone in the family might have and not be able to express. Low self esteem, a feeling of loss and helplessness are just a few that might be issues that could be addressed and talked through. Although most parents and children do not receive enough or any family therapy, it should be the goal of any good case manager to encourage this and to have it start as soon as possible".

Material taken from: http://www.kidsmentalhealth.org/family-therapy-for-children-with-behavioral-disorders/

4. Quizz

What is the meaning of the word "disorder" in psychology

O It is when everything is in chaos.
O It is the opposite of order.
O It is when a condition reaches the level of being personally harmful or harmful to others.
O It is just a word they use to make regular problems sound special.

What two categories make up emotional disorders?

O Mood and anxiety disorders.
O Personality and anxiety disorders.
O Mood and personality disorders.
O Emotional disorders are their own category.

What is a mood disorder?

O It is when a person is normally depressed about a situation, like someone dying.
O One where the person experiences either extreme depression or mania, or both on separate occasions.
O When a person experiences the happiness of their baby being born.
O Mood disorder is not a term used by psychologists.

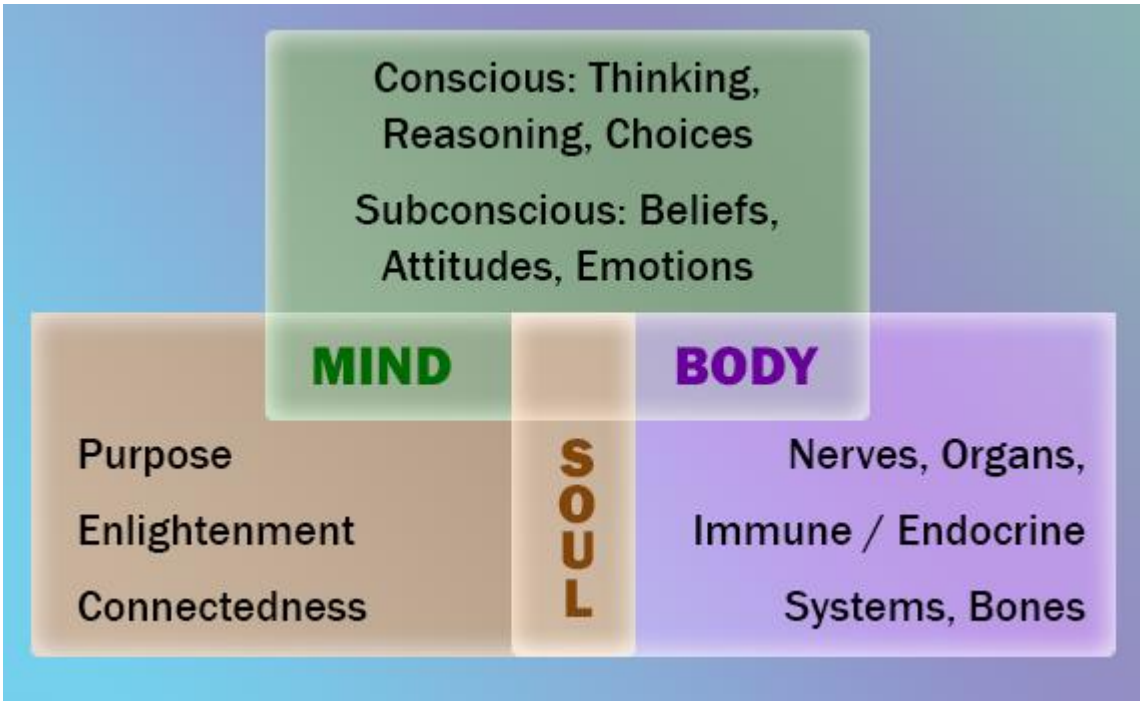
Crossword is taken from:

https://study.com/academy/practice/quiz-worksheet-understanding-emotional-disorders.html

For discussion

Use this picture and discuss about these questions:

1. How to find the soul, mind and body harmony for yourself?
2. How to help find the harmony of soul, mind, and body for your child?



Picture taken from https://www.trivedieffect.com/inspiration-blog/soul-mind-and-body/

5. Where can you find assistance and ask for special help? Special Education Services

Dr. O'Connor a Toronto psychologist, provides psychological services to children, adolescents and young adults, their families and the helping professionals who work with them. Her services, which she offers through her practice - *Assessment, Consultation and Treatment* ***Solutions - (ACTS),*** help promote positive outcomes in children, adolescents and young adults despite the challenges they face. https://www.solutionsforchildproblems.com/

Friendship Circle

friendshipcircle.org/blog/2014/10/01/how-do-i-get-special-education-services-for-my-child-with-special-needs/

Special Education Services

http://www.edb.gov.hk/en/edu-system/special/policy-and-initiatives/special-edu-serv/

6. Resources for parents

Helpful Websites and Blogs

https://study.com/academy/lesson/what-is-an-emotional-disorder-definition-types.html

http://www.kidsmentalhealth.org/childrens-behavioral-and-emotional-disorders/

https://en.wikipedia.org/wiki/Emotional_and_behavioral_disorders

https://www.trivedieffect.com/inspiration-blog/overly-emotional-disorder/

http://www.parentcenterhub.org/emotionaldisturbance/#def

http://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Pages/Emotional-and-Behavioral-Disorder.aspx

http://www.open.edu/openlearn/health-sports-psychology/health/emotions-and-emotional-disorders/content-section-1.1

https://www.education.com/reference/article/emotional-behavioral-disorders-defined/

https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/social-and-emotional-problems.aspx

https://www.solutionsforchildproblems.com/child-with-emotional-problems.html

https://www.solutionsforchildproblems.com/child-anxiety-disorder.html

https://www.solutionsforchildproblems.com/alcoholic-parents.html

http://www.pacer.org/cmh/does-my-child-have-an-emotional-or-behavioral-disorder/

http://cheapbargain.net/topic/20/help+children+adhd/?utm_campaign=853B3Bc&utm_term=kids%20emotional%20problems&utm_medium=b&g_ti=kwd-78134148605358:

Family Voices:

For Parents When They Learn Their Child Has a Disability For Parents When They Learn Their Child Has a Disability by Patricia McGill Smith

http://www.familyvoices.org/admin/work_caring/files/nd20.pdf

When You Learn That Y ou Learn That Your Child Has a Disability our Child Has a Disability by Carole Brown, Samara Goodman, and Lisa Küpper

http://www.familyvoices.org/admin/work_caring/files/nd20.pdf

The Role of Families in Health Promotion: Family Wisdom about Health and Wellness Knowledge, Strategies, and Barriers Leslie M. Carroll, MUP Melissa C. Vickers, MEdhttp://www.familyvoices.org/admin/miscdocs/files/TheWisdom-of-Families_10-07-2014.pdf

Center for Parent Information and Resources

Buzz from the Hub | Social-Emotional Developmenthttp://www.parentcenterhub.org/buzz-sept2015/

Spotlight on…Social-Emotional Development

http://www.parentcenterhub.org/buzz-sept2015/

Social and Emotional Development

https://www.zerotothree.org/early-development/social-and-emotional-development

Videos

Lisa Feldman BarrettYou aren't at the mercy of your emotions — your brain creates them

https://www.ted.com/talks/lisa_feldman_barrett_you_aren_t_at_the_mercy_of_your_emotions_your_brain_creates_them

Sangu Delle *There's no shame in taking care of your mental health*

https://www.ted.com/talks/sangu_delle_there_s_no_shame_in_taking_care_of_your_mental_health?referrer=playlist-the_struggle_of_mental_health

Associations and Societies

COPMI Children of Parents with a Mental Illness

COPMI promotes better outcomes for children and families where a parent experiences mental illness. http://www.copmi.net.au/kids-young-people

The Children's Defense Fund

Political advocacy and support to ensure a level playing field for all children. They focus on impacting policies and programs that lift children out of poverty; protect them from abuse and neglect; and ensure their access to health care, quality education and a moral and spiritual foundation.http://www.childrensdefense.org/?referrer=http://www.pacer.org/cmh/resources/finding-organizations-that-can-help/

Mental Health America

Provides current mental health news, brochures, fact sheets at no cost and other publications for purchase on various mental health topics.http://www.mentalhealthamerica.net/

National Alliance on Mental Illness (NAMI)

NAMI is a grass roots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.https://www.nami.org/About-NAMI

Center for Child and Human Development

National Center hosted at Georgetown University, focused on Trauma Informed Care and Early Interventions for children with mental health challenges. Posts current summaries of effective strategy research.https://gucchd.georgetown.edu/behavioral-health.php

Early Childhood Technical Assistance Center (ECTA)

ECTA is an OSEP funded comprehensive technical assistance center for t young children with disabilities. It includes reviews of early childhood interventions, research, information on early childhood programs (619 and early childhood special education), data, outcomes, and more.http://ectacenter.org/

Technical Assistance Center for Social Emotional Intervention for Young Children (TACSEI)

The goal of the State/TACSEI Partnership is to plan, implement and sustain a professional development system to enhance the knowledge and skills of the early childhood work force in meeting the social emotional needs of young children, particularly those with or at risk for delays or disabilities in inclusive and natural environments. http://www.pacer.org/cmh/resources/finding-organizations-that-can-help/challengingbehavior.fmhi.usf.edu/

Portland Research and Training Center

Provides updates on research, publications, and other activities as well as information about developments in the field of infant and toddler mental health.
https://contextualscience.org/portland_psychotherapy_clinic_research_amp_trainin

7. Parenting children with behavioral disorders

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Chapter summary

In this part we are talking about *Parenting children with behavioral disorders*. We introduce the basic concepts of behavioral disorders. Statistics are presented too. We are discussing questions: What threats should be taken seriously? When is there more risk associated with threats from children and adolescents? What should be done if parents or others are concerned? and other issues. We introduce The List of Behavioral Disorders too. We as well present some strategies of Parenting children with behavioral disorders. To encourage a discussion we suggested some questions. We also provided other useful information such as *Helpful Websites, Center for Parent Information and Resources, Videos, Associations and Societies* and more.

1. Glossary/Words to know/Definitions

"Behavioral disorders involve a pattern of disruptive behaviors in children that last for at least 6 months and cause problems in school, at home and in social situations. Behavioral disorders involve a pattern of disruptive behaviors in children that last for at least 6 months and cause problems in school, at home and in social situations.Nearly everyone shows some of these behaviors at times, but behavior disorders are more serious".

https://www.mentalhealth.gov/what-to-look-for/behavioral-disorders

"Emotional and **behavioral disorders** (EBD; sometimes called emotional disturbance or serious emotional disturbance) refer to a disability classification used in educational settings that allows educational institutions to provide special education and related services to students that have poor social or academic adjustment that cannot be better explained by biological abnormalities or a developmental disability".

https://en.wikipedia.org/wiki/Emotional_and_behavioral_disorders

"**Attention deficit hyperactivity disorder (ADHD)** is a mental health disorder that can cause above-normal levels of hyperactive and impulsive behaviors. People with ADHD may also have trouble focusing their attention on a single task or sitting still for long periods of time".

https://www.healthline.com/health/adhd

"Disruptive behavior disorders are a group of behavioral problems. They are called "disruptive" because affected children literally disrupt the people and activities around them (including at home, at school and with peers). The most common types of disruptive behavior disorder are oppositional defiant disorder (ODD) and conduct disorder. Children with oppositional defiant disorder display a persistent pattern of angry outbursts, arguments and disobedience. While this behavior is usually directed at authority figures, like parents and teachers, it can also target siblings, classmates and other children".

http://www.childrenshospital.org/conditions-and-treatments/conditions/disruptive-behavior-disorders

"**Anxiety disorders** are the most common form of emotional disorder and can affect anyone at any age. According to the American Psychiatric Association, women are more likely than men to be diagnosed with an anxiety disorder".

https://www.healthline.com/health/anxiety

Depression is classified as a mood disorder. It may be described as feelings of sadness, loss, or anger that interfere with a person's everyday activities. It is estimated that depression affects 1 in 20 Americans.

https://www.healthline.com/health/depression

Bipolar disorder is a mental illness marked by extreme mood swings from high to low, and from low to high. Highs are periods of mania, while lows are periods of depression. The mood swings may even become mixed, so you might feel elated and depressed at the same time.

https://www.healthline.com/health/could-it-be-bipolar-seven-signs-to-look-for

"Conduct disorder is a group of behavioral and emotional problems that usually begins during childhood or adolescence. Children and adolescents with the disorder have a difficult time following rules and behaving in a socially acceptable way. They may display aggressive, destructive, and deceitful behaviors that can violate the rights of others. Adults and other children may perceive them as "bad" or delinquent, rather than as having a mental illness".

https://www.healthline.com/health/conduct-disorder#types

2. You are not alone –

Some important facts

"**Bipolar disorder** isn't a rare diagnosis. A 2005 study found that 2.6 percent of the U.S. population, or more than 5 million people, are living with some form of bipolar disorder. Symptoms tend to appear in a person's late teens or early adult years, but they can occur in children as well. Women are more likely to receive bipolar diagnoses than men, though the reason for this remains unclear".

https://www.healthline.com/health/could-it-be-bipolar-seven-signs-to-look-for

"It is estimated that **depression affects** 1 in 20 Americans".

https://www.healthline.com/health/depression

Youth with EBD:

"Have the worst graduation rate of all students with disabilities. Nationally, only 40 percent of students with EBD graduate from high school, compared to the national average of 76 percent.

Are three times as likely as other students to be arrested before leaving school.

Are twice as likely as other students with other disabilities (e.g. developmental or learning) to be living in a correctional facility, halfway house, drug treatment center, or on the street after leaving school.

Are twice as likely as students with other disabilities to become teenage mothers.

Up to 85 percent of children in juvenile detention facilities have disabilities that make them eligible for special education services, yet only 37 percent had been receiving any kind of services in their school.

Youth with emotional disturbances are 13 times more likely to have been arrested while still in school compared to students with other disabilities.

10 to 25 percent of students with EBD enroll in post-secondary education (compared to 53 percent of typical population)".

https://whocaresaboutkelsey.com/the-issues/statistics#ebdStatistics

3. **Theoretical section on the topic of our specific chapter**
"Parents are an essential part of treatment for their child's disruptive behavior disorder. The most effective interventions we've seen are parent-based."

Eugene d'Angelo, PhD, chief of Children's Division of Psychology
http://www.childrenshospital.org/conditions-and-treatments/conditions/disruptive-behavior-disorders

"All kids misbehave some times. And some may have temporary behavior problems due to stress. For example, the birth of a sibling, a divorce, or a death in the family may cause a child to act out. Behavior disorders are more serious. They involve a pattern of hostile, aggressive, or disruptive behaviors for more than 6 months. The behavior is also not appropriate for the child's age.

Warning signs can include

- Harming or threatening themselves, other people or pets
- Damaging or destroying property
- Lying or stealing
- Not doing well in school, skipping school
- Early smoking, drinking or drug use
- Early sexual activity
- Frequent tantrums and arguments
- Consistent hostility toward authority figures

If you see signs of a problem, ask for help. Poor choices can become habits. Kids who have behavior problems are at higher risk for school failure, mental health problems, and even suicide. Classes or family therapy may help parents learn to set and enforce limits. Talk therapy and behavior therapy for your child can also help".

The text taken from: https://medlineplus.gov/childbehaviordisorders.html#summary

"Behavioral disorders may involve:

- Inattention
- Hyperactivity
- Impulsivity
- Defiant behavior
- drug use

• criminal activity

Behavioral disorders include:

• Attention Deficit Hyperactivity Disorder (ADHD)

• Oppositional Defiant Disorder (ODD)

• Conduct Disorder"

The text taken from: https://www.mentalhealth.gov/what-to-look-for/behavioral-disorders

Some very important questions and very significant answers

What threats should be taken seriously?

"Examples of potentially dangerous or emergency situations with a child or adolescent include:

Threats or warnings about hurting or killing someone

Threats or warnings about hurting or killing oneself

Threats to run away from home

Threats to damage or destroy property

Child and adolescent psychiatrists and other mental health professionals agree that it is very difficult to predict a child's future behavior with complete accuracy. A person's past behavior, however, is still one of the best predictors of future behavior. For example, a child with a history of violent or assaultive behavior is more likely to carry out his/her threats and be violent".
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Childrens-Threats-When-Are-They-Serious-065.aspx

When is there more risk associated with threats from children and adolescents?

"The presence of one or more of the following increases the risk of violent or dangerous behavior:

• Past violent or aggressive behavior (including uncontrollable angry outbursts)

• Access to guns or other weapons

• Bringing a weapon to school

• Past suicide attempts or threats

• Family history of violent behavior or suicide attempts

• Blaming others and/or unwilling to accept responsibility for one's own actions

• Recent experience of humiliation, shame, loss, or rejection

• Bullying or intimidating peers or younger children

• A pattern of threats

• Being a victim of abuse or neglect (physical, sexual, or emotional)

• Witnessing abuse or violence in the home

• Themes of death or depression repeatedly evident in conversation, written expressions, reading selections, or artwork

• Preoccupation with themes and acts of violence in TV shows, movies, music, magazines, comics, books, video games, and Internet sites

• Mental illness, such as depression, mania, psychosis, or bipolar disorder

• Use of alcohol or illicit drugs

• Disciplinary problems at school or in the community (delinquent behavior)

- Past destruction of property or vandalism
- Cruelty to animals
- Firesetting behavior
- Poor peer relationships and/or social isolation
- Involvement with cults or gangs
- Little or no supervision or support from parents or other caring adult".

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Childrens-Threats-When-Are-They-Serious-065.aspx

What should be done if parents or others are concerned?

"When a child makes a serious threat it should not be dismissed as just idle talk. Parents, teachers, or other adults should immediately talk with the child. If it is determined that the child is at risk and the child refuses to talk, is argumentative, responds defensively, or continues to express violent or dangerous thoughts or plans, arrangements should be made for an immediate evaluation by a mental health professional with experience evaluating children and adolescents. Evaluation of any serious threat must be done in the context of the individual child's past behavior, personality, and current stressors. In an emergency situation or if the child or family refuses help, it may be necessary to contact local police for assistance or take the child to the nearest emergency room for evaluation. Children who have made serious threats must be carefully supervised while awaiting professional intervention. Immediate evaluation and appropriate ongoing treatment of youngsters who make serious threats can help the troubled child and reduce the risk of tragedy".
https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Childrens-Threats-When-Are-They-Serious-065.aspx

Be Patient with Your Children

"Empathy, a cooperative attitude, and a calm temperament are crucial traits for parents to adopt as their child struggles. Also, knowing when to ask for help is key.

If your child's behavior becomes disruptive to the regular running of your household or their education, or if they become violent, it's time to talk to a professional.

Raising children with behavioral problems isn't easy. But before you rush to diagnose them or turn into a strict disciplinarian, reach out for help. Your pediatrician can provide insight into whether your child's behavior is normal for their age, and provide resources for assistance".

https://www.healthline.com/health/parenting/behavioral-disorders-in-children#5

4. *Let's talk:*

1. Parenting Styles: Which One Is Right for You?

"When we talk about parenting styles, there are four main types, one of which is most effective in raising well-adjusted and well-behaved children:

- **Authoritarian parenting:** Strict rules with no compromise, and no input from the children.

• **Authoritative parenting:** Strict rules, but parents are willing to listen and cooperate with their children. More of a democracy than authoritarian parenting.

• **Permissive parenting:** Few rules, and few demands put on children. There is little to no discipline in this home, and parents typically take on the role of friend.

• **Uninvolved parenting:** No rules and very little interaction. These parents are detached and may reject or neglect their children".

Text taken from:
https://www.healthline.com/health/parenting/behavioral-disorders-in-children#1

Indicative Questions for Discussion:

1. Complete the table:

Parenting Styles	Advantages (your viewpoint)	Disadvantages(your viewpoint)
Authoritarian parenting		
Authoritative parenting		
Permissive parenting		
Uninvolved parenting		

2. Which way is the right one for You?
3. Why? State your argument, please.
4. What new have you learned about Parenting Styles?
5. What was useful?

Here are the basics of a good behavioral management plan that you can use at home. *Read it and discuss together:*

"Define Behaviors

The first step is to identify the target behaviors that you either want to encourage or discourage. These behaviors should be specific, observable, and measurable (so everyone can agree

whether or not the behavior happened). An example of poorly defined behavior is "being good" or "acting up." A well-defined behavior would be "grabbing another child's toy" or "sitting nicely at the dinner table."

Set the Stage

Once you've targeted behaviors you want to see more or less of, you should focus on the antecedents, or the preceding factors that make the behaviors more or less likely to occur. These are ways to increase the likelihood of positive behavior and decrease the likelihood of negative behavior.

Adjust the environment.

For a homework session, for instance, remove distractions like video screens and toys, provide a snack if your child is hungry, and schedule breaks to help him stay alert.

Make expectations clear.

You'll get better cooperation if you think clearly about what you are expecting, and tell your child with words. For example, explain that bedtime is at 8:00 on school nights. It starts with putting on pajamas, brushing teeth, using the bathroom, and a half hour of reading together in bed before lights out. It's even more helpful to write expectations out and hang them up (using pictures if your child can't read yet).

Countdown to transitions.

Whenever possible, prepare your child for an upcoming transition. Let her know when there are 10 minutes remaining before she must come to dinner or start cleaning up. Then remind her when there are two minutes left. Be sure that you actually make the transition at the stated time.

Give a choice when possible.

Providing two options is a good way to set up structure while empowering your child to have a say. You might ask, "Do you want to take a shower before dinner or after?" or "Do you want to turn off the TV or should I?" The key is that the choice should be presented calmly and politely.

Use "when, then" statements.

These are a useful tool that offers a clear expectation as well as a reward for cooperating. For example: "When you complete your homework, then you will get to play on the iPad." Make sure you present the "when, then" calmly and limit how often you repeat yourself.

Give Instructions Effectively

Psychologists help parents choose pick the right words to get the results they want.

Use statements, not questions.

"Please take out your math worksheet" or "Please sit down" is better than "Are you ready to get do your homework?"

Tell your child what to do instead of what not to do.

If he or she is jumping on the couch, you want to say, "Please get down from the couch" instead of "Please stop jumping."

Be clear and specific.

Instead of "Go ahead" say, "Please go start reading your assignment." Instead of "Settle down" say "Please use your inside inner voice."

Give instructions calmly and respectfully.

This helps your child learn to be polite when speaking to others. He or she will also learn to listen to calm instructions instead of listening only when you shout instructions or his or her name several times.

Say it once.

After you give an instructions, wait a few seconds, rather than repeating what you said. Your child will learn to listen to instructions the first time, rather than assuming you will say them again.

Choose the Right Consequences

A great deal of managing misbehavior is focused on preventing it, but the second important piece is responding properly to it. Let's look at consequences that don't have the desired effect -- encouraging positive behaviors and discouraging negative ones -- and then at some that do.

Ineffective Consequences

Negative attention.

Children value attention from the important adults in their life so much that any attention -- positive or negative -- is better than none. Reacting emotionally to your child's misbehavior -- "Don't speak to me like that!" -- will actually increase the behavior over time. Criticizing him or her in this way can also hurt his or her self-esteem.

Delayed consequences.

It's best to respond immediately. For every moment that passes after a behavior, your child is less likely to link her behavior to the consequence. It becomes punishing for the sake of punishing, and will be much less likely to actually change his or her behavior.

Disproportionate consequences.

At times, you may be so frustrated that you take away a privilege for a week or a month. In addition to being a delayed consequence, this may be developmentally inappropriate for a child who doesn't have a sense of time. A huge consequence can be demoralizing, so that he or she could give up even trying to behave.

Positive consequences.

When your child dawdles instead of putting on his or her shoes or picking up his or her blocks (toys), and you get so impatient that you do it for him or her, you increasing the likelihood the child will dawdle again next time.

Effective Consequences

Praise for appropriate behavior.

Catching your child being good makes the behavior more likely to happen again. Praise is most valuable when it's specific. Instead of saying "Great job!" you can say, "Thank you for putting away your blocks (toys) neatly!" Repeating or paraphrasing a child's words ("Thank you for asking me if you could use the computer") shows that you are listening and helps encourage his or her verbal skills. When you describe a positive behavior, you help your child understand exactly what you expect.

Active ignoring.

This strategy should be used only for minor misbehaviors, not for aggression or very destructive behavior. When your child starts to misbehave, you deliberately withdraw your attention. This means no eye contact, no talking, and no nonverbal interaction. No sighing, no smiling, no nothing. The active part is that you're waiting for your child to behave properly. In case of whining, you are waiting for him or her to speak in an appropriate tone. In case of rough play, you are waiting for gentle play. Then give positive attention as soon as the desired behavior starts. When your child shifts to a respectful tone, for instance, you should immediately make eye contact, smile, and say, "Thank you for speaking to me nicely." By withholding your attention until you get positive behavior, you are teaching her what behavior gets you to engage.

Reward menus.

Rewards are a tangible way to give your child positive feedback for desired behaviors. Not a bribe, a reward is something a child earns -- it's an acknowledgment that she's doing something that's difficult for her. Rewards are most effective as motivators when your child can select from a range of choices -- which not only gives her a feeling of control, but also reduces the possibility that a given reward will lose its appeal over time. A reward can be a privilege or activity (time on the iPad, a story, a trip to the playground) or a tangible reward (small treasures like marbles or stickers, or points towards a small purchase). Give rewards for specific target behaviors, post them on a chart so your child can see them, deliver or withhold them consistently, and update them every couple of weeks.

Time-outs.

A time-out is one of the most effective consequences, but it is also one of the hardest to use correctly. A time-out should be given immediately after your child engages in a negative behavior that you've explained in advance will lead to time-out. If time-outs happen randomly -- once you've been pushed to the limit -- your child won't know what to expect. During a time-out, do not talk to your child until it is over. Rather than having a specific time limit based on your child's age, the time-out should end immediately after your child has been calm and quiet briefly, so she receives the

"reward" for acting appropriately. Don't forget this last, very important, step: If you issued the time-out because your child wouldn't comply with a task, tell him or her to complete the original task. That way, the time-out won't have been a successful avoidance strategy for him or her".

Text taken from: https://www.parents.com/health/mental/dealing-with-disruptive-behavior/

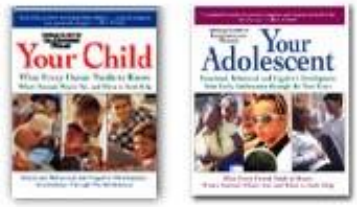
1. Complete the table:

Type of good behavioral management	**In what situations can I use it?**	**Provide an example**
Define Behaviors		
Set the Stage		
Give Instructions Effectively		
Choose the Right Consequences		

2. What new have you learned about the Parenting Styles?
3. What did you find useful?
4. What is necessary to use? Why?
5. What I will not use? Why?

5. Where can you find assistance and ask for special help?

American Academy of Childand Adolescent Psychiatry
https://www.aacap.org/AACAP/Families_and_Youth/Family_Resources/Home.aspx?hkey=5bd95eb8-aabb-4110-b706-90216cbe33df



See also: *Your Child* (1998 Harper Collins) / *Your Adolescent* (1999 Harper Collins)

Order *Your Child* from Harper Collins
Order *Your Adolescent* from Harper Collins

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/PANS_and_PANDAS-Sudden_Onset_of_OCD_Symptoms.aspx

BehavioralDisordes SAGE journals

http://journals.sagepub.com/home/bhd

6. Resources for parents

Helpful Websites

https://www.healthline.com/health/parenting/behavioral-disorders-in-children#5
http://www.childrenshospital.org/conditions-and-treatments/conditions/disruptive-behavior-disorders
http://keltymentalhealth.ca/mental-health/disorders/behavioural-disorders
https://www.betterhealth.vic.gov.au/health/healthyliving/behavioural-disorders-in-children
http://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Pages/Emotional-and-Behavioral-Disorder.aspx
https://www.boystown.org/parenting/guides/Pages/behavioral-disorders.aspx
https://www.jax.org/jax-mice-and-services
http://www.richardsonthebrain.com/behavioral-disorders/
https://www.cheatsheet.com/health-fitness/common-adult-behavioral-disorders.html/?a=viewall
https://chriskresser.com/heavy-metals-and-behavioral-disorders-in-children/
http://ilccbd.org/index.html
https://www.educationcorner.com/behavioral-disorders-in-the-classroom.html
http://www.npaschools.org/emotional-or-behavioral-disorders

Center for Parent Information and Resources

AACAP's Resource Centers empower consumers through patient education. Each AACAP Resource Center contains consumer friendly definitions, answers to frequently asked questions, a definition of clinical resources, expert interviews, abstracts from the *JAACAP*, and Scientific Proceedings and Facts for Families relevant to each disorder.

- Attention Deficit/Hyperactivity Disorder (ADHD) Resource Center
- Anxiety Disorders Resource Center
- Autism Resource Center
- Bipolar Disorder Resource Center
- Bullying Resource Center
- Child Abuse Resource Center
- Conduct Disorders Resource Center
- Depression Resource Center
- Disaster Resource Center
- Military Families Resource Center
- Oppositional Defiant Disorder Resource Center
- Substance Use Resource Center

https://www.aacap.org/AACAP/Families_and_Youth/Family_Resources/Home.aspx?hkey=5bd95eb8-aabb-4110-b706-90216cbe33df

Centers for Disease Control and Prevention

https://www.cdc.gov/childrensmentalhealth/behavior.html

Associations and Societies

Children's Mental Health and Emotional of Behavioral Disorders Project

http://www.pacer.org/cmh/does-my-child-have-an-emotional-or-behavioral-disorder/

Boys Town

https://www.boystown.org/parenting/guides/Pages/behavioral-disorders.aspx

Kids Mental Health

http://www.kidsmentalhealth.org/childrens-behavioral-and-emotional-disorders/

PINEY RIDGE

http://www.pineyridge.net/behavioral-disorders

Video

https://www.ted.com/talks/carina_morillo_to_understand_autism_don_t_look_away

https://www.ted.com/talks/alix_generous_how_i_learned_to_communicate_my_inner_life_with_asperger_s

https://www.ted.com/talks/faith_jegede_what_i_ve_learned_from_my_autistic_brothers

https://www.ted.com/talks/rebecca_brachman_could_a_drug_prevent_depression_and_ptsd

https://www.ted.com/talks/mandy_len_catron_a_better_way_to_talk_about_love

https://www.ted.com/talks/andrew_solomon_depression_the_secret_we_share

https://www.ted.com/talks/kevin_briggs_the_bridge_between_suicide_and_life

https://www.ted.com/talks/heather_lanier_good_and_bad_are_incomplete_stories_we_tell_ourselves
https://www.ted.com/talks/arik_hartmann_our_treatment_of_hiv_has_advanced_why_hasn_t_the_stigma_

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